Nos. 18-1323, 18-1460

IN THE

Supreme Court of the United States

JUNE MEDICAL SERVICES L.L.C., *et al.*,

Petitioners,

v.

DR. REBEKAH GEE, Secretary, Louisiana Department of Health and Hospitals,

Respondent.

DR. REBEKAH GEE, Secretary, Louisiana Department of Health and Hospitals,

Cross-Petitioner,

v.

JUNE MEDICAL SERVICES L.L.C., *et al.*,

Cross-Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF SOCIAL SCIENCE RESEARCHERS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

ALAN S. GILBERT
Counsel of Record
LEAH R. BRUNO
JACQUELINE A. GIANNINI
DENTONS US LLP
233 South Wacker Drive, Suite 5900
Chicago, Illinois 60606
(312) 876-8000
alan.gilbert@dentons.com

Attorneys for Amici Curiae

292794

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici curiae are social science researchers who have collectively spent decades conducting and publishing peer-reviewed research about the safety, incidence, and health impacts of abortion in the United States. In particular, their research focuses on effects of state regulations on the health of women seeking abortions.

In *Gonzales v. Carhart*, this Court identified a lack of data measuring the impact of abortion on women's mental health and wellbeing.[2] In the years since that decision, researchers from across the country have rigorously examined the impact of abortion on women: conducting epidemiological studies of abortion complications and the impact of denial of abortion care; epidemiological and economic studies of impacts of restrictive abortion policies; and health services research on women's experiences seeking care. *Amici* include dozens of individual researchers working in this field, some of whom have authored studies on abortion in Louisiana.

Amici are therefore well-suited to assess the likely effects of Louisiana's statute on women's health. *Amici* have an interest in ensuring that robust scientific research

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1. Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that they authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amici* or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Rule 37.3(a), counsel for *amici* represent that all parties have consented to the filing of this brief.

2. *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).

is used to analyze evidence related to and impacts of laws purporting to improve women's health. Methodologically sound research should include appropriate comparison groups, describe the sampling strategy, and clearly distinguish correlation and causation. As *amici's* thorough research has shown, abortion is already very safe, and laws that create barriers to abortion services harm, rather than improve, women's health. Additionally, their research demonstrates that women face barriers to bringing legal challenges to abortion regulations, including harassment and a lack of knowledge regarding the regulations themselves.

A full list of *amici* is attached as an appendix to this brief.

SUMMARY OF ARGUMENT

Section 40.1061.10 of Louisiana's Revised Statutes ("Act 620" or "the Act") imposes an admitting-privileges requirement on abortion providers that is identical to the requirement in Texas House Bill 2 ("HB2") that this Court found unconstitutional in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) ("*WWH*"). Act 620 requires abortion providers to have admitting-privileges at a hospital within 30 miles of the clinic where the abortion is performed.[3] As this Court found in *WWH*, the admitting-privileges requirement did not confer "medical benefits sufficient to justify the burdens upon access" that it imposed. 136 S. Ct. at 2300. This holding is amply supported by scientific research demonstrating that the admitting-privileges requirement has no health or safety

3. La. Stat. Ann. § 40:1061.10(A)(2)(a).

benefits and instead serves to delay or deny access to abortion, which has significant negative consequences for women's physical health and their socioeconomic outcomes.

As demonstrated by the research cited herein, abortion is already one of the safest medical procedures performed in the United States—complications arise from abortions less frequently than from other common outpatient procedures not subject to similar legal restrictions. Rather than making abortion safer, Act 620 will increase the limited risks of the procedure by making it more difficult for women to obtain care during the earliest stages of pregnancy, when abortion is safest. As a result, more women are likely to require second-trimester abortions, attempt to self-induce with harmful methods or carry the unwanted pregnancy to term, each of which poses greater risks to women's health and safety. In addition to the direct medical risks, social science research demonstrates that restricting access to abortion has negative socioeconomic consequences for women. Available scientific studies show, in other words, that the effect of the admitting-privileges requirement on women's health, safety and well-being will be precisely the opposite of what the Act's proponents assert.

For these and the reasons set forth more fully below, *amici curiae* urge this Court to overturn the Fifth Circuit Court of Appeal's opinion and find Act 620 to be an unconstitutional undue burden on the fundamental rights of women in Louisiana.

ARGUMENT

I. Abortion Is Very Safe And Act 620 Does Not Make It Safer.

A. Abortion Is a Safe, Common Medical Procedure.

Years of research conclusively demonstrate that abortion is a very safe, common medical procedure. Although the number of abortions performed annually in the United States is declining, more than 850,000 abortions were performed in 2017,[4] and one in four women will have an abortion before the age of 45.[5] Prior to the adoption of Act 620, around 10,000 abortions were performed annually in Louisiana.[6] Abortion patients include women of every race, religion, and socioeconomic group, and the majority already have children.[7]

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4. Rachel K. Jones, Elizabeth Witwer and Jenna Jerman, *Abortion Incidence and Service Availability in the United States*, 2017, Guttmacher Inst. at 7 (2019), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf ("Jones, Witwer & Jerman, *Abortion Incidence*").

5. Rachel K. Jones and Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107(12) Am. J. Pub. Health 1904, 1908 (2017), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042.

6. Jones, Witwer & Jerman, *Abortion Incidence*, *supra* note 4, at 14; *see also June Med. Servs. LLC v. Kliebert*, 250 F. Supp. 3d 27, 39 (M.D. La. 2017).

7. *See* Jenna Jerman, Rachel K. Jones and Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst. (2016), https://www.guttmacher.

Nationally, the vast majority of abortions—88%—are performed in the first trimester of pregnancy.[8] In 2017, 39% of all abortions, and more than half occurring prior to 10 weeks' gestation, were performed using a combination of two medications, mifepristone and misoprostol,[9] which are dispensed in a clinic and require no special equipment or facilities ("medication abortions").[10] Mifepristone may be taken in the clinic or at home, and misoprostol is taken by the patient at home, usually 24-48 hours later.[11]

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org/report/characteristics-us-abortion-patients-2014 (discussing demographic trends among abortion patients) ("Jerman, Jones & Onda, *Characteristics*").

8. *Fact Sheet: Induced Abortion in the United States*, Guttmacher Inst. at 2 (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states. That figure holds true in Louisiana as well. *See Induced Termination of Pregnancy (ITOP) Data*, Louisiana Dep't of Health Vital Records (2019) http://ldh.la.gov/assets/oph/Center-RS/vitalrec/leers/ITOP/ITOP_Reports/Ap18_T22.pdf.

9. Jones, Witwer & Jerman, *Abortion Incidence*, *supra* note 4, at 12.

10. National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, The National Academies Press, 1-4 (2018), https://dktwomancare.org/pdfresources/The%20Safety%20and%20Quality%20of%20Abortion%20Care%20in%20the%20United%20States.pdf ("NASEM, *Safety*").

11. *Practice Bulletin: Medical Management of First-Trimester Abortion*, The Am. C. Obstetricians and Gynecologists and Soc'y of Fam. Planning, 143 at 7 (2014), https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf; *FDA Label for Mifeprex*, https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

Aspiration abortion, the other common method of first-trimester abortion, is typically performed without general anesthesia and takes only a few minutes to complete.[12] In the United States, the vast majority of abortions are performed in clinics; only about 5% are performed in hospitals or private physicians' offices.[13]

Complication rates from abortion are very low—around 2%.[14] Most abortion complications are minor, including easily treatable infections and incomplete medication abortions that later require aspiration.[15] Major

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12. Lisa M. Keder, *Best Practices in Surgical Abortion*, 189 Am. J. Obstetrics & Gynecology 418, 419 (2003); Katharine O'Connell et al., *First-Trimester Surgical Abortion Practices: A Survey of National Abortion Federation Members*, 79 Contraception 385, 389 (2009); *see also Clinical Practice Handbook for Safe Abortion*, World Health Org. at 26 (2014), http://apps.who.int/iris/bitstream/10665/97415/1/9789241548717_eng.pdf.

13. Jones, Witwer & Jerman, *Abortion Incidence*, *supra* note 4, at 1.

14. *See e.g.* Diana Taylor et al., *Standardizing the classification of abortion incidents: the Procedural Abortion Incident Reporting and Surveillance (PAIRS) Framework*, 96 Contraception at 9-10 (2017) (finding the overall frequency of abortion incidents was 2.4%); Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstetrics & Gynecology 175, 181 (2015), https://www.ansirh.org/sites/default/files/publications/files/upadhyay-jan15-incidence_of_emergency_department_visits.pdf (finding 2.1% abortion-related complication rate) ("Upadhyay, *Incidence*"); Kari White, Erin Carroll, and Daniel Grossman, *Complications from first-trimester aspiration abortion: A systematic review of the literature*, 92(5) Contraception 422 (2015) ("White, Carroll & Grossman, *Complications*").

15. Upadhyay, *Incidence*, *supra* note 14, at 181.

complications are extremely rare, occurring at a rate of approximately 0.23%[16] to 0.50%[17] across gestational ages and types of abortion methods.

The risk of death from an abortion is extraordinarily low: nationally, fewer than one in 100,000 abortion patients die from an abortion-related complication.[18] A person is ten times more likely to be struck by lightning than a woman having an abortion is to die.[19]

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16. *Id.* at 181 (defining "major complications" as requiring hospitalization, surgery, or a blood transfusion).

17. *See* White, Carroll & Grossman, *Complications*, *supra* note 14, at 434; *see also* Sarah C.M. Roberts et al., *Association of Facility Type With Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319(24) JAMA 2497, 2501 (2018), https://jamanetwork.com/journals/jama/fullarticle/2685987.

18. The mortality rate for abortion is approximately 0.0007%. Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 Obstetrics & Gynecology 258, 261 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4554338/pdf/nihms718534.pdf ("Zane"); *see also* Tara C. Jatlaoui et al., *Abortion Surveillance - United States, 2015*, 67(13) MMWR Surveillance Summaries, at 9-10 (2018), https://www.cdc.gov/mmwr/volumes/67/ss/pdfs/ss6713a1-H.pdf; Elizabeth G. Raymond and David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012), http://unmfamilyplanning.pbworks.com/w/file/fetch/119312553/Raymond%20et%20al-Comparative%20Safety.pdf (estimating a rate of 0.0006% for 1998–2005) ("Raymond & Grimes").

19. *See How Dangerous is Lightning?*, Nat'l Weather Service, https://www.weather.gov/safety/lightning-odds (stating that the chance of being struck by lightning in one's lifetime is approximately one in 15,300, or 0.0065%).

B. Strict Regulations Like Act 620 Do Not Apply to Many Outpatient Procedures that Are Riskier than Abortion.

Louisiana providers who perform medical procedures with similarly low risks, or even greater risks are not required to obtain admitting-privileges. This demonstrates the absence of medical necessity for Act 620's requirement that abortion providers obtain such privileges. As the District Court found, "[f]irst trimester surgical abortions are nearly identical to D & Cs to complete a spontaneous miscarriage" yet "[p]hysicians are not required to have admitting privileges in order to perform D & Cs[.]"[20] Indeed, research also shows that abortion is safer than or poses similar risks to other common outpatient procedures, for which Louisiana does not impose the same strict admitting-privileges requirement on physicians.[21] For example:

- The overall complication rate for abortions (2%) is much lower than for miscarriage treatment (9%)[22] and wisdom teeth removal (5%).[23]

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20. *June*, 250 F. Supp. 3d at 61–62.

21. Brief for Petitioners at 36, n. 4, *June Medical Services LLC v. Gee* (No. 18-1323).

22. Sarah C.M. Roberts et al., *Miscarriage Treatment-Related Morbidities and Adverse Events in Hospitals, Ambulatory Surgery Centers, and Office-Based Settings*, J. Patient Safety at 1 (2018), https://journals.lww.com/journalpatientsafety/Abstract/publishahead/Miscarriage_Treatment_Related_Morbidities_and.99298.aspx#pdf-link.

23. Chi H. Bui, Edward B. Seldin, and Thomas B. Dodson, *Types, frequencies, and risk factors for complications after third molar extraction*, 61(12) J. Oral Maxillofacial Surgery 1379 (2003).

- The mortality rate for abortions is roughly the same as for in-office dental surgery[24] and outpatient plastic surgery procedures.[25]

This data indicates that there is no medical need for singling out abortion for additional regulation.

C. Research Demonstrates that Act 620 Will Not Raise the Quality of Care or Promote Women's Health.

Setting aside the fact that abortion is already very safe, there is no evidence to suggest that Act 620's admitting-privileges requirement will make abortion any safer. Conceding that "the benefits conferred by Act 620 are not huge," the Fifth Circuit found that "[t]he legislative history of Act 620 plainly evidences an intent to promote women's health . . . by ensuring a higher level of physician competence and by requiring continuity of care."[26] But the available research does not support the position that

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24. *See, e.g.*, Edward M. D'Eramo, William J. Bontempi and Joanne B. Howard, *Anesthesia Morbidity and Mortality Experience Among Massachusetts Oral and Maxillofacial Surgeons*, 66 J. Oral Maxillofacial Surgery 2421, 2421–22 (2008) (reviewing literature finding mortality rates between 0.001% and 0.003%); Andres de Lima, Brian M. Osman, and Fred E. Shapiro, *Safety in office-based anesthesia: an updated review of the literature from 2016 to 2019*, 32 Current Opinion Anesthesiology at 3 (2019) (finding 0.2% rate of unplanned transfer to hospital for in-office dental surgery).

25. Elizabeth G. Raymond et al., *Mortality of induced abortion, other outpatient surgical procedures and common activities in the United States*, 90(5) Contraception 476 (2014).

26. *June Med. Servs. LLC v. Gee*, 905 F.3d 787, 805, 807 (5th Cir. 2018).

the admitting-privileges restriction will improve abortion patients' hospital-based care in the few instances when they need such care or make abortion any safer than it already is.[27]

Perhaps most significantly, the admitting-privileges requirement can be of no help to the great number of Louisiana women who travel long distances for their abortion and then experience a complication once they return home, since women tend to travel to the hospital closest to their home and not the hospital where the provider has admitting-privileges.[28] In Louisiana, women now travel on average 58 miles for an abortion and, as discussed below, that distance will likely increase

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27. Ushma D. Upadhyay et al., *Admitting privileges and hospital-based care after presenting for abortion: A retrospective case series*, 54 Health Services Res. 425, 435 (2019), https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.13080 (study finding that "physician admitting privilege laws did not appear to impact the ways in which abortion patients received hospital-based care" and that "[p]reexisting mechanisms of communication and coordination appear to safeguard continuity of care" from abortion clinic to hospital) ("Upadhyay, *Admitting privileges*"); Nancy Berglas et al., *The effect of facility characteristics on patient safety, patient experience, and service availability for procedures in non-hospital-affiliated outpatient settings: A systematic review*, 13(1) PLOS One at 13 (2018), https://www.ncbi.nlm.nih.gov/pubmed/29304180.

28. Ushma D. Upadhyay et al., *Distance Traveled for an Abortion and Source of Care After Abortion*, 130(3) Obstetrics & Gynecology 616, 621 (2017) (finding that "traveling greater distance for an abortion is associated with an increased likelihood of seeking subsequent care" at an emergency room rather than the abortion provider); Upadhyay, *Admitting Privileges*, *supra* note 27, at 435.

if clinics close as a result of Act 620.[29] The distances Louisiana women travel now is at the longer end of national averages.[30] Given these distances, it is unlikely the nearest hospital will be the one where their abortion provider holds privileges.

Nor does the admitting-privileges requirement improve the quality of abortion care by serving as a credentialing mechanism, as Louisiana argues and the Fifth Circuit found. A licensed doctor's ability to obtain admitting-privileges is not a reliable indication of his or her competence. The District Court's finding that, "hospitals may deny privileges or decline to consider an application for privileges for myriad reasons unrelated to competency"[31] is supported by research. Among other

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29. Abortion Access in Louisiana in 2018, ANSIRH (2018), https://www.ansirh.org/research/louisianas-admitting-privileges-law; Abortion Access in Louisiana in 2018 Infographic, ANSIRH (2018), https://www.ansirh.org/sites/default/files/publications/files/abortion_access_in_lousiana.pdf ("ANSIRH Infographic"); Jonathan M. Bearak, Kristen Lagasse Burke and Rachel K. Jones, *Disparities and change over time in distance women would need to travel to have an abortion in the USA: a spatial analysis*, 2 Lancet Pub. Health e493, e495 (2017), https://www.thelancet.com/action/showPdf?pii=S2468-2667%2817%2930158-5.

30. Liza Fuentes and Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, J. Women's Health at 7 (2019), https://www.liebertpub.com/doi/pdf/10.1089/jwh.2018.7496 (study finding that more than 17% of women obtaining an abortion in 2014 traveled 50 miles or more).

31. *June*, 250 F. Supp. 3d at 46; *see also WWH*, 136 S. Ct. at 2313 ("The admitting-privileges requirement does not serve any relevant credentialing function."); *see also Change in number of*

conditions, many hospitals require physicians to admit a certain number of patients or perform a minimum number of hospital-based surgeries annually to maintain their privileges.[32] This requirement is especially difficult for abortion providers because so few abortions lead to a hospital admission.[33] Ironically, therefore, one of the reasons compliance with the admitting-privileges requirement is so difficult is that abortion is so safe.[34]

In short, available research simply does not support Louisiana's claim that Act 620 will improve women's health.

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*physicians providing abortion care in Texas after HB*2, Texas Pol'y Evaluation Project Res. at 2 (2016), http://sites.utexas.edu/txpep/files/2018/02/TxPEP-Admitting-Privileges-Brief.pdf (listing various reasons other than competency for which admitting-privileges may be denied).

32. *See, e.g.*, *id.* at 2; *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 792 (7th Cir. 2013) (noting that admitting-privileges criteria include "how frequently the physician uses the hospital (that is, the number of patient admissions), the quantity of services provided to the patient at the hospital, the revenue generated by the physician's patient admissions, and the physician's membership in a particular practice group or academic faculty . . . .").

33. Only approximately 0.03% of abortions require a same-day ambulance transfer to an emergency room. *See* Upadhyay, *Incidence*, *supra* note 14, at 180. And only 6.4% of women receiving an abortion seek treatment in an emergency department within six weeks of the abortion. *Id*. Of those, the majority (59.2%) seek emergency care for reasons unrelated to the abortion. *Id*. at 180–81.

34. *See* Section I.A., *supra*.

II. Research Shows That Act 620 Will Harm, Not Improve, Women's Health.

Act 620 not only fails to improve women's health, it will actually harm women. If Act 620 is implemented, it will dramatically reduce the number of abortion providers in Louisiana, resulting in increased wait times and the average distance women must travel to obtain an abortion and force many women to seek care in other states. These outcomes will create delays and raise the costs of the procedure—hurting women both economically and physically.

A. Act 620 Will Reduce the Number of Abortion Providers, Increase Travel Distances, Raise Costs and Prevent Some From Getting Abortions.

While Act 620's admitting-privileges requirement does not make abortion safer, it certainly will make abortions more difficult to obtain. Louisiana women already report that current travel distances make it difficult for them to obtain an abortion.[35] As the District Court found, if Act 620 is implemented, Louisiana women will be left with only one abortion provider, meaning that women will be forced to travel "significant distances to reach a clinic[.]"[36] As a consequence, the percentage of Louisiana women who would have to travel more than 50 miles to an abortion clinic would increase from 45% up to

35. Erin Carroll and Kari White, *Abortion patients' preferences for care and experiences accessing services in Louisiana*, Contraception X (in press) ("Carroll & White").

36. *June*, 250 F. Supp. 3d at 83.

91%.[37] Currently, 1% of Louisiana women of reproductive age live more than 150 miles from the nearest abortion facility; if two of the remaining three clinics close, this will increase to up to 53%.[38]

Studies confirm that restrictions such as the admitting-privileges requirement not only make access to abortion more difficult, but also make it more expensive. The average out-of-pocket cost for an abortion is approximately $474.[39] In addition, women incur other costs to obtain an abortion, including traveling (potentially hundreds of miles) to their nearest provider, taking time off work, and obtaining childcare.[40] These types of costs increased for women in Texas when their nearest abortion clinic closed because of the state's admitting-privileges law.[41]

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37. ANSIRH Infographic, *supra* note 29; *see also* Jones, Witwer & Jerman, *Incidence*, *supra* note 4 at 17 (in 2017, 72% of women in Louisiana lived in a county without an abortion clinic).

38. ANSIRH Infographic, *supra* note 29.

39. 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, e214 (2014) (noting that out-of-pocket costs can be as high as $3,700) (Roberts, *Out-of-Pocket Costs*).

40. Jill Barr-Walker et al., *Experiences of women who travel for abortion: A mixed methods systematic review*, 14(4) PLOS One e0209991, 17-18 (2019), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0209991 ("Participants in these studies explicitly cite the cost of travel expense, which include the cost of transportation, accommodation, childcare expenses, and lost wages as a barrier to reaching timely care when needing to travel for services.").

41. Caitlin Gerdts et al., *Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of*

Women, including in Louisiana, report having to delay or not pay bills for rent, food utilities, and other essentials in order to pay for an abortion.[42] Studies further show while some Louisiana women are able to get the money together by delaying or not paying other expenses, other women cannot.[43] For example, between 18% and 37% of Medicaid-eligible women who would otherwise have an abortion continue their pregnancies because Medicaid funding is unavailable.[44]

Restrictive Law in Texas, 106(5) AJPH Research 857, 861 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4985084/pdf/AJPH.2016.303134.pdf.

42. Rachel K. Jones, Ushma D. Upadhyay and Tracy A. Weitz, *At What Cost? Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173, e176 (2013), https://www.researchgate.net/publication/236674611_At_What_Cost_Payment_for_Abortion_Care_by_US_Women; Carroll & White, *supra* note 35.

43. *Id.*; Sarah C.M. Roberts, Nancy Berglas and Katrina Kimport, *Complex Situations: economic insecurity, mental health, and substance use among women who consider – but do not have - abortions,* PLOS ONE (in press) (2019) ("Roberts, Berglas & Kimport, *Complex Situations*").

44. Stanley K. Henshaw et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, Guttmacher Inst., at 27 (June 2009) https://www.guttmacher.org/sites/default/files/report_pdf/medicaidlitreview.pdf ("Henshaw"); *see also* Sarah C.M. Roberts et al., *Estimating the proportion of Medicaid-eligible pregnant women in Louisiana who do not get abortions when Medicaid does not cover abortion*, 19(78) BMC Women's Health, at 4 (2019) ("[A]pproximately 3000 Louisiana women with Medicaid give birth per year instead of having an abortion because Medicaid does not cover abortion.").

The increased costs and travel distances resulting from clinic closures will also force many women to delay their abortion. Cost, both for travel and for the procedure, is one of the primary causes for delay in obtaining an abortion.[45] More than half of women seeking abortions report that raising money for the abortion delayed their procedure.[46] Some women postpone their abortions for financial reasons as long as two to three weeks, and in some cases into the second trimester, which only increases costs.[47] The mean price of an aspiration abortion in the first trimester is $508 and the mean price for a medication abortion is $535. By contrast, the median price at twenty weeks is $1,195, meaning a delay can double the cost of the procedure.[48] Other reasons for delay are not knowing where to find abortion care and not having means to travel to an abortion provider.[49] All of these causes for delay are

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45. Diana Greene Foster and Katrina Kimport, *Who Seeks Abortions at or After 20 Weeks?*, 45 Perspectives on Sexual & Reproductive Health 210, 212–15 (2013) https://onlinelibrary.wiley.com/doi/epdf/10.1363/4521013 ("Foster & Kimport"); Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1692 (2014) https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301378 ("Upadhyay, *Denial*").

46. Roberts, *Out-of-Pocket Costs*, *supra* note 39, at e215.

47. Henshaw, *supra* note 44, at 28.

48. Rachel K. Jones, Meghan Ingerick and Jenna Jerman, *Differences in Abortion Service Delivery in Hostile, Middleground, and Supportive States in 2014*, 28(3) Women's Health Issues 212, 215-216 (2018) https://www.sciencedirect.com/science/article/pii/S1049386717305364?via%3Dihub.

49. Upadhyay, *Denial*, *supra* note 45, at 1689; *see also* Megan L. Kavanaugh, Jenna Jerman & Lori Frohwirth, *"It's not something you talk about really": Information barriers*

exacerbated when clinics become more scarce and there are fewer providers that can serve the same number of women. These additional costs most affect poor women who have fewer alternative options.[50]

Increased travel distances resulting from clinic closures will also effectively deny abortions for some women. Several studies found that the number of abortions decreased as travel distance increased following implementation of admitting-privileges laws.[51] Research shows "even relatively small numbers of clinic closures can have large magnitude effects if the clinics that close are geographically remote from the next nearest service provider[,]"[52] as would be the case in Louisiana.[53] A

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encountered by women who travel long distances for abortion care, 100 Contraception 79, 81 (2019), https://www.contraceptionjournal.org/article/S0010-7824(19)30126-X/pdf.

50. Roberts, Berglas & Kimport, *Complex Situations, supra* note 43.

51. Daniel Grossman et al., *Change in Distance to Nearest Facility and Abortion in Texas, 2012 to 2014*, 317(4) JAMA 437, 438 (2017), https://jamanetwork.com/journals/jama/fullarticle/2598282 ("Grossman, *Distance*"); Joanna Venator and Jason Fletcher, *Undue burden beyond Texas: an analysis of abortion clinic closures, births, and abortions in Wisconsin*, NBER Working Paper No. 26362, 29 (2019) (analyzing effects of clinic closures in Wisconsin) ("Venator & Fletcher"); Jason M. Lindo et al, *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, NBER Working Paper No. 23366, 21-22 (2018), https://www.nber.org/papers/w23366.pdf ("Lindo, *How Far*").

52. Venator & Fletcher, *supra* note 51, at 29; *see also* Grossman, *Distance*, *supra* note 51, at 438; Lindo, *How Far*, *supra* note 51, at 21-22.

53. ANSIRH Infographic, *supra* note 29.

study in Texas found that when there was even a small increase in travel distance—from five miles to 25 miles or more—the abortion rate was reduced by 10%.[54] Effects are further exacerbated by clinic congestion, that is, when a reduced number of clinics lack capacity to serve the increased number of people seeking abortions.

B. Delaying or Effectively Denying Access to Abortion Negatively Affects Women's Physical Health.

The District Court found that reducing access to abortion increases the likelihood that the procedure will be delayed until a later gestational period, will be self-induced using harmful methods, or will not be obtained at all.[55] Research demonstrates that each of these outcomes carries with it increased risks to a woman's health and safety that could be avoided if abortion services were accessible.

First, research shows that limiting access to abortion increases the percentage of abortions occurring in the

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54. Lindo, *How Far*, *supra* note 51, at 14.

55. "The vast majority of women who have abortions in Louisiana are poor. As a result of that poverty, the burden of traveling farther to obtain an abortion would be significant, fall harder on these women than those who are not poor and cause a large number of these women to either not get an abortion, perform the abortions themselves, or have someone who is not properly trained and licensed perform it." *June*, 250 F. Supp. 3d at 59 (citations omitted); *see also id.* at 83 (With fewer clinics available in Louisiana, "those women who can access an abortion clinic will face lengthy delays, pushing them to later gestational ages with associated increased risks.").

second-trimester.[56] Indeed, one study of the effect of the 2014 clinic closures in Texas as a result of Texas' admitting-privileges statute found a 13% increase in second-trimester abortions in 2014 compared to 2012.[57] This increase was due, in part, to greater clinic congestion.[58] Even though abortion is very safe, delaying the procedure increases the medical risks to the patient because the chance of a major complication is higher in the second trimester than in the first.[59]

Delay also makes it more likely that a woman will be unable to obtain an abortion before Louisiana's twenty-week post-fertilization gestational limit. Social scientists estimated that in 2008 approximately 4,000 women in the United States were denied abortions each year because of gestational limits.[60] If Act 620 goes into full effect, the number of women denied an abortion in Louisiana due to gestational limits is likely to rise. Because marginalized populations, such as people of color and those with low-incomes, are already more likely to have second-trimester

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56. *See supra* notes 45-50 and accompanying text; *see also* Kari White et al., *Change in second-trimester abortion after implementation of a restrictive state law*, 133(4) *Obstetrics & Gynecology* 771, 777 (2019).

57. *Id*.

58. *Id*. at 777-78; Lindo, *How Far*, *supra* note 51, at 14-15.

59. Upadhyay, *Incidence*, *supra* note 14, at 181; *see also* Willard Cates, Jr. et al., *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Planning Persp. 266, 268 (1977) ("Our findings clearly demonstrate that *any* delay increases the risk of complications to a pregnant woman who wishes an abortion."); *see also* Zane, *supra* note 18, at 5.

60. Upadhyay, *Denial*, *supra* note 45, at 1692.

procedures,[61] these obstacles may make it even more difficult for them to obtain abortion care.

The inability to access abortion care may cause more women to attempt self-induction.[62] A primary reason women attempt self-induction is because they do not have the money to travel to or pay for a clinic-based abortion.[63] While some women are able to safely self-manage their own abortions with abortion pills they obtain online, self-induction, especially through methods other than abortion pills, carries risks.[64] Commonly reported methods of

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61. Rachel K. Jones and Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions*, 12(1) PLOS One e0169969, 11-13 (2017) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0169969.

62. *See* Abigail Aiken et al., *Motivations and Experiences of People Seeking Medication Abortion Online in the United States*, 50(4) Perspectives on Sexual and Reproductive Health 157, 161 (2018) ("Aiken, *Motivations*"); *see also WWH*, 136 S. Ct. at 2321 ("When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux*, at great risk to their health and safety.") (J. Ginsburg, concurring).

63. *Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options*, Texas Pol'y Evaluation Project Res. at 2 (2015), https://ibisreproductivehealth.org/sites/default/files/files/publications/TxPEP_Texas%20womens%20experiences%20self%20induction_ResearchBrief_17Nov2015.pdf (the second top reason for women in Texas was because their local clinic had closed) ("*Texas Women*"); *see also* Aiken, *Motivations*, *supra* note 62, at 159.

64. Daniel Grossman et al., *Self-Induction of Abortion Among Women in the United States*, 18(36) Reprod. Health Matters 136, 143 (2010), https://www.tandfonline.com/doi/pdf/10.1016/S0968-

attempted self-induction that may be harmful include herbal or homeopathic remedies, getting punched in the abdomen, using alcohol or illicit drugs, or taking hormonal pills.[65] Women in Louisiana are already attempting self-induction, some with safer options such as abortion pills[66] and others using harmful options.[67]

Restricting access to abortion also makes abortion completely out of reach for many women, thereby forcing women to carry the pregnancy to term.[68] This

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8080%2810%2936534-7?needAccess=true (discussing medical and legal risks associated with self-induced abortion).

65. Daniel Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Texas Pol'y Evaluation Project Res. at 3 (2015). One study estimated that 1.3% of all abortion patients in the US have attempted self-induction using the second drug used in the FDA-approved medication abortion regimen pills. Jerman, Jones & Onda, *Characteristics*, *supra* note 7, at 8; *see also Texas Women, supra* note 63, at 1 (2012 study of women in Texas found that 7% "reported having attempted to self-induce abortion for their current pregnancy").

66. Abigail Aiken et al., *Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States*, Res. and Practice at e4 (2019), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2019.305369 (study showing that women in Louisiana requested abortion medications online).

67. Sarah C.M. Roberts et al., *Consideration of and Reasons for Not Obtaining Abortion Among Women Entering Prenatal Care in Southern Louisiana and Baltimore, Maryland*, 16 Sexuality Res. and Soc. Pol'y 476, 482 (2019), https://link.springer.com/content/pdf/10.1007%2Fs13178-018-0359-4.pdf.

68. Venator & Fletcher, *Undue burden*, *supra* note 51, at 22 (in study of Wisconsin following clinic closures, researchers

too increases the risk of injury and death, as a woman is fourteen times more likely to die from giving birth than as a result of an abortion,[69] and pregnancy-related deaths are higher among black women than white women in the U.S. and in Louisiana.[70] Approximately 29% of hospital deliveries involve at least one obstetric complication,[71] compared to roughly 2% for abortion, which are primarily minor complications.

While reduced availability of abortion services harms women, increased availability is generally correlated with improvements in public health. States that provide public funds for abortions, for example, have lower infant

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reported "that a 100 mile increase in distance from the nearest clinic is associated with a 3.71 percent increase in the number of births per month"); *see also* Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496, 498 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4179978/pdf/nihms616799.pdf (following closure of Texas clinics, abortion rate decreased 13%); Liza Fuentes et al., *Women's experiences seeking abortion care shortly after the closure of clinics due to restrictive law in Texas*, 93(4) Contraception 292 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4896137/pdf/nihms-788814.pdf; Lindo, *How Far*, *supra* note 51, at 15.

69. *See* Raymond & Grimes, *supra* note 18, at 216.

70. Louisiana Maternal Mortality Review Report 2011-2016, Louisiana Dep't of Health, at 22 (August 2018), http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/maternal/2011-2016_MMR_Report_FINAL.pdf.

71. Cynthia J. Berg et al., *Overview of Maternal Morbidity During Hospitalization for Labor and Delivery in the United States: 1993-1997 and 2001-2005*, 113(5) Obstetrics & Gynecology 1075, 1077 (2009).

mortality rates.[72] Research has also found that women denied wanted abortions are more likely to experience continued intimate partner violence from the man involved in the pregnancy than women who are able to receive a wanted abortion.[73] Women denied abortions also experience worse health over five years, compared to those women who received a wanted abortion.[74]

C. Restricting Access to Abortion Does Not Improve Women's Mental Health and Emotional Well-Being.

Reducing access to abortion has no positive effect on women's mental health and emotional well-being, as some have posited, and may be detrimental in the short-term. In *Gonzales v. Carhart*, this Court stated that, although "no reliable data [was available] to measure the phenomenon," presumably "some women come to regret their choice" to have an abortion and that "[s]evere depression and loss of esteem can follow."[75] Recent studies and systematic

72. Nancy Krieger et al., *Reproductive justice & preventable deaths: state funding, family planning, abortion, and infant mortality*, US 1980-2010, 2 SSM Population Health 277, 292 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4950871/pdf/main.pdf.

73. Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12:144 BMC Med., at 5 (2014), https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-014-0144-z.

74. Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 Annals of Internal Med. 238, 244 (2019).

75. *Gonzales*, 550 U.S. at 159.

reviews of the literature—including a report by the American Psychological Association and the National Academies of Sciences, Engineering, and Medicine—have found that abortion does *not* have a negative impact on women's mental health.[76]

Research has found that having an abortion does not lead to increased likelihood of symptoms of depression, anxiety, or post-traumatic stress or of suicidal ideation compared to carrying an unwanted pregnancy to term.[77]

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76. Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 439–448 (2008); Julia R. Steinberg, Charles E. McCulloch and Nancy E. Adler, *Abortion and Mental Health: Findings from the National Comorbidity Survey-Replication*, 123 Obstetrics & Gynecology 263, 265–69 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3929105/pdf/nihms-541175.pdf; Brenda Major et al., *Abortion and Mental Health: Evaluating the Evidence*, 64(9) Am. Psychologist 863, 885–86 (2009), https://www.apa.org/pubs/journals/features/amp-64-9-863.pdf; Brenda Major et al., *Report of the APA Task Force on Mental Health and Abortion*, Am. Psychological Assoc. at 89 (2008), https://www.apa.org/pi/women/programs/abortion/mental-health.pdf; NASEM, *Safety*, *supra* note 10, at 149-152.

77. M. Antonia Biggs et al., *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74(2) JAMA Psychiatry 169, 177 (2017), http://unmfamilyplanning.pbworks.com/w/file/fetch/119310024/Biggs%20et%20al-Womens%20Mental%20Health%20and%20Well%20Being.pdf ("[D]uring a 5-year period, women receiving wanted abortions had similar or better mental health outcomes than those who were denied a wanted abortion.") ("Biggs, *Mental Health*"); *see also* M. Antonia Biggs et al., *Five-Year Suicidal Ideation Trajectories Among Women Receiving or Being Denied an Abortion*, 175 (9) Am. J. Psychiatry 845 (2018), https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2018.18010091; M. Antonia Biggs et al., *Does abortion increase women's risk for*

Nor does it lead to a higher rate of diagnosis of mental health disorders.[78] Over time, most women have more positive emotions about their abortion than negative ones,[79] with relief being the most common response.[80] A recent longitudinal study found that the predicted probability of a woman reporting that abortion was the right decision for her was over 99% at each follow up interview over the three years following her abortion.[81] No evidence suggests that restricting access to abortion does anything to improve mental health outcomes.[82]

There is, however, evidence that barriers to abortion access can have a short-term negative impact on mental

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post-traumatic stress? Findings from a prospective longitudinal cohort study, 6 BMJ Open e009698 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4746441/pdf/bmjopen-2015-009698.pdf.

78. M. Antonia Biggs, John M. Neuhaus and Diana Greene Foster, *Mental Health Diagnoses 3 years After Receiving or Being Denied an Abortion in the United States*, 105(12) Am. J. Pub. Health 2557, 2561 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4638270/pdf/AJPH.2015.302803.pdf.

79. Corinne Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10(7) PLOS One e0128832 at 7-8 (2015), http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0128832&representation=PDF ("Rocca, *Decision Rightness*").

80. Corinne Rocca et al., *Women's Emotions One Week After Receiving or Being Denied an Abortion in the United States*, (45) (3) Perspectives on Sexual and Reproductive Health 122, 128 (2013), https://onlinelibrary.wiley.com/doi/epdf/10.1363/4512213.

81. Rocca, *Decision Rightness*, *supra* note 79, at 10.

82. Biggs, *Mental Health, supra* note 77.

health symptoms. For example, approximately one week after seeking an abortion, women who are denied abortions because of gestational age limits are more likely to report symptoms of anxiety than women who receive an abortion.[83] There is thus no basis to conclude that abortion restrictions like Act 620 improve women's mental health.

D. Barriers to Abortion Have Negative Socioeconomic Effects on Women and Children.

The most common reasons women seek abortions are socioeconomic.[84] In a study of nearly 1,000 US abortion patients, 40% cited financial reasons, including being unable to afford the basic needs of life for themselves, not being able to take care of another child, and unemployment.[85] Further, approximately 60% of abortion patients already have children, and nearly one-third of women seeking an abortion say that their reason for wanting an abortion is to care for the children they already have.[86]

Research confirms that women's concerns about their ability to provide for a child are often well-founded. One

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83. *Id.* at 172.

84. M. Antonia Biggs, Heather Gould and Diana Greene Foster, *Understanding Why Women Seek Abortions in the US*, 13(29) BMC Women's Health at 4-8 (2013), https://bmcwomenshealth.biomedcentral.com/track/pdf/10.1186/1472-6874-13-29 ("Biggs, *Understanding*").

85. *Id.* at 5.

86. Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics 183, 183 (2019), https://www.jpeds.com/article/S0022-3476(18)31297-6/pdf ("Foster, *Effects*").

recent study found women denied a wanted abortion were less financially secure in subsequent years than those who received an abortion.[87] One year after seeking an abortion, women who were denied an abortion were more likely than similarly situated women who obtained an abortion to be receiving public assistance (76% versus 44%), more likely to be living below the poverty level (67% versus 56%), and less likely to be employed full-time (48% versus 58%).[88] In addition, being denied an abortion increases the chances that a woman's existing children live in poverty.[89] Being able to delay the birth of a subsequent child increases the probability that the next child is intended[90] and lives in economic security.[91] Another study found that young

87. Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108(3) AJPH 407, 411-12 (2018), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304247 (finding "large and statistically significant differences in the socioeconomic trajectories of women who were denied wanted abortions compared with women who received abortions—with women denied abortions facing more economic hardships").

88. *Id*. at 412-13 ("carrying the unwanted pregnancy to term led to almost a 4-fold increase in the odds that woman's household income was below the [federal poverty line]").

89. Foster, *Effects*, *supra* note 86, at 185.

90. Ushma D. Upadhyay et al., *Intended pregnancy after receiving vs. being denied a wanted abortion*, 99(1) Contraception 42, 46 (2019).

91. Diana Greene Foster et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion*, 172(11) JAMA Pediatrics 1053, 1058 (2018), https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698454.

women who chose to have an abortion were ultimately better off economically and educationally than their peers who carried to term.[92] Other studies have shown that women who receive a wanted abortion are more likely to have vocational goals, have a positive outlook on their future, and achieve aspirational life plans within one year than women who are denied an abortion.[93]

Finally, because most women seeking an abortion already have children,[94] restricted access to abortion may also have a negative impact on the health of their current and future children. A national study of abortion patients showed that, among patients with children, a commonly cited reason for choosing to have an abortion was the concern that having another child would compromise the care given to existing children.[95] Two-thirds of the women who cited existing children as a reason for seeking an abortion were at or below the poverty line and received little assistance from their partners.[96] Restricted access

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92. Laurie Schwab Zabin et al., *When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy*, 21 Fam. Planning Persp. 248, 254 (1989).

93. Ushma D. Upadhyay, M. Antonia Biggs and Diana Greene Foster, *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15(102) BMC Women's Health, 1, 6–9 (2015), https://bmcwomenshealth.biomedcentral.com/track/pdf/10.1186/s12905-015-0259-1.

94. *See* Jerman, Jones & Onda, *Characteristics*, *supra* note 7, at 1.

95. Biggs, *Understanding*, *supra* note 84, at 6.

96. Rachel K. Jones et al., *"I Would Want to Give My Child, Like, Everything in the World": How Issues of Motherhood Influence Women Who Have Abortions*, 29 J. Fam. Issues 79, 88 (2008).

to abortion has a disproportionate impact on these low-income women and their families.

In sum, recent social science and public health studies on the effects of abortion have thoroughly refuted claims that reducing access to abortion improves physical, mental, or economic wellbeing. Indeed, restrictions like those in Act 620 have been shown to generally harm, rather than improve, the health of women, their children, and the general public. Act 620's admitting-privileges requirement, in other words, is an "[u]nnecessary health regulation[] that ha[s] the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion."[97]

III. Women Who Seek Abortions Face Insurmountable Obstacles To Bringing Legal Challenges.

While women face numerous obstacles in obtaining an abortion, requiring them to bring legal challenges to restrictive abortion laws is both unreasonable and unrealistic. Requiring women to take the lead on legal challenges ignores research findings that many women are hesitant to disclose their abortion to family and friends, let alone risk disclosure to the public through a lawsuit. A decision to terminate a pregnancy is fundamentally a personal and private decision, and research shows that many women would not want to risk the potential repercussions they may face by becoming the plaintiff in a lawsuit. Further, while women are affected by abortion restrictions in various ways, many are unaware of the legislation imposing these restrictions and thus are in no position to bring a legal challenge against them.

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97. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992).

A. Research Shows that Many Women Do Not Want to Disclose That They Had An Abortion, and Those Who Do Face Harassment.

Research confirms that many patients do not want to disclose that they had or sought an abortion and are concerned about their privacy. As explained in one study, "abortion is a sensitive topic, which can raise participant anxiety or concern related to confidentiality."[98] Indeed, one study found that two-thirds of women believe that other people would look down on them if they knew about an abortion that she had or is considering.[99]

Abortion stigma is not only perceived, but is in fact experienced by many women.[100] Women may experience harassment from the moment they arrive at the clinic and encounter protestors.[101] One study of people who

98. Jenny O'Donnell et al., *"I wouldn't even know where to start": unwanted pregnancy and abortion decision-making in Central Appalachia*, 26(54) Reproductive Health Matters 98, 110 (2018). One woman in the study told researchers that her abortion was "a huge secret[.]" *Id.* at 108.

99. Kristen M. Shellenberg and Amy O. Tsui, *Correlates of perceived and internalized stigma among abortion patients in the USA: An exploration by race and Hispanic ethnicity*, 118(2) Int'l J. Gynecology and Obstetrics S152, S153 (2012).

100. Kristen M. Shellenberg, *Social stigma and disclosure about induced abortion: Results from an exploratory study*, 6 Global Pub. Health S111, S118-119 (2011).

101. Katrina Kimport, Kate Cockrill and Tracy A. Weitz, *Analyzing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experience of abortion clinics*, 85 Contraception 204, 207 (2012), https://www.ansirh.org/_documents/library/kimport-cockrill-weitz_contraception2-2012.

shared their abortion experience publicly found that 53% experienced harassment online and 36% experienced harassment in person.[102] Fourteen percent reported feeling that they or their loved ones were in physical danger, and 47% reported that negative experiences from sharing their story caused problems in their life, including mental or emotional stress and damage to their reputation.[103] Many participants who chose to use only a first name or an alias still experienced these harms.[104]

Given the demonstrated negative consequences of publicly disclosing one's abortion experience, even under pseudonym, requiring a woman to become a plaintiff in a very public lawsuit would subject her to extraordinary hardship.

B. Women Are Often Unaware of Abortion Laws that Affect Their Ability to Access Abortion.

Despite the widespread effect that restrictive abortion laws like Act 620, Texas' HB2, and other restrictions have

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pdf (finding that "protestors increased women's feelings of stigma, secrecy and shame, confirming aspects of the social myth of abortion"); Carroll & White, *supra* note 35.

102. *Experiences of Harassment and Support after Sharing One's Personal Abortion Story Publicly*, ANSIRH, at 2 (2019) https://www.ansirh.org/sites/default/files/publications/files/abortion_disclosure_experiences_of_harassment_and_support.pdf (of those participants who disclosure their abortion experience, 53% experience harassment online and 36% experience harassment in person).

103. *Id.*

104. *Id.*

on women's access to abortion, women are often unaware of these laws and the statutory requirements limiting their access.[105] Researchers found that, like women in other states, women in Louisiana are largely unaware of abortion laws, even if those laws prevent them from obtaining an abortion.[106] Studies also show that even in a state like Texas, where abortion restrictions were the subject of widespread media attention, most women were unaware of the legislation or its restrictions.[107] One study of abortion patients in states with mandatory waiting periods found that "most of the women in the study were unaware that the waiting period was a state-mandated policy" and instead thought that it was a clinic-imposed restriction.[108]

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105. Diana Lara et al., *Knowledge of Abortion Laws and Services Among Low-Income Women in Three United States Cities*, 17 J. Immigrant Minority Health 1811, 1813-1814 (2015); Kate Cockrill and Tracy A. Weitz, *Abortion patients' perceptions of abortion regulation*, 20 *Women's Health Issues* 12, 15 (2010) ("Overall, the women in our study did not have knowledge of state-level regulations on abortion.") ("Cockrill & Weitz, *Perceptions*").

106. *Women's Awareness of Abortion Laws in Louisiana*, ANSIRH Issue Brief, at 3 (Nov. 2019), https://www.ansirh.org/sites/default/files/publications/files/womens_awareness_of_abortion_laws_in_louisiana.pdf.

107. Kari White et al., *Women's Knowledge of and Support for Abortion Restrictions in Texas: Findings from a Statewide Representative Survey*, 48(4) Perspectives on Sexual and Reproductive Health 189, 194-195 (2012), https://onlinelibrary.wiley.com/doi/full/10.1363/48e8716 (study of Texas women finding that "more than half of [ ] respondents reported that they either had not heard of any abortion laws passed in the last five years or were not very aware of recent legislation, despite widespread local and national media coverage").

108. Cockrill & Weitz, *Perceptions*, *supra* note 105, at 15-16.

Allowing institutions and care providers to bring challenges to abortion restrictions is vital as they are undeniably aware of the contested legislation and its effects on their patients' access, and are directly affected by such requirements. Given the harms women have been found to face when publicly disclosing that they have had an abortion even when they seek to stay anonymous, it is both unfair and unrealistic to expect individual women to pursue claims in their personal capacity.

CONCLUSION

For these, and the foregoing reasons, *amici curiae* respectfully urge this Court to reverse the Fifth Circuit Court of Appeal's September 26, 2018 opinion, and find that Act 620 unduly burdens Louisiana women who seek to exercise their fundamental right to abortion.

Respectfully submitted,

Alan S. Gilbert
Counsel of Record
Leah R. Bruno
Jacqueline A. Giannini
Dentons US LLP
233 South Wacker Drive, Suite 5900
Chicago, Illinois 60606
(312) 876-8000
alan.gilbert@dentons.com

Attorneys for Amici Curiae

APPENDIX

APPENDIX — LIST OF *AMICI CURIAE*

The institution is listed for identification purposes only and the views expressed in the brief do not necessarily reflect the views of *amici's* affiliated institutions.

Nancy Adler, PhD
University of California, San Francisco

Abigail R.A. Aiken, MD, MPH, PhD
University of Texas at Austin

Elizabeth Oltmans Ananat, PhD
Duke University

Nicole Austin, PhD
McGill University

Jonathan Bearak, PhD
Guttmacher Institute

Nancy F. Berglas, DrPH
University of California, San Francisco

Danielle Bessett, PhD
University of Cincinnati

M. Antonia Biggs, PhD
University of California, San Francisco

Kelly Blanchard, MSc
Ibis Reproductive Health

Appendix

Mara Buchbinder, PhD
University of North Carolina at Chapel Hill

Sarah K. Cowan, PhD
New York University

Blair G. Darney, PhD, MPH
Oregon Health Sciences University

Amanda Dennis, DrPH, MBE
Society of Family Planning

Sheila Desai, DrPH
Guttmacher Institute

Dabney P. Evans, PhD
Emory University

Angel M. Foster, DPhil, MD, AM
University of Ottawa

Diana Greene Foster, PhD
University of California, San Francisco

Lori Freedman, PhD
University of California, San Francisco

Liza Fuentes, DrPH, MPH
Guttmacher Institute

Maria Gallo, PhD
Ohio State University

Appendix

Caitlin Gerdts, PhD, MHS
Ibis Reproductive Health

Jessica D. Gipson, MPH, PhD
University of California, Los Angeles

Anu Manchikanti Gomez, PhD
University of California, Berkeley

Daniel Grossman, MD
University of California, San Francisco

Sofia Gruskin, JD, MIA
University of Southern California

Kelli Stidham Hall, PhD, MS
Emory University Rollins School of Public Health

Cynthia Harper, PhD
University of California, San Francisco

S. Marie Harvey, DrPH, MPH
Oregon State University

Jenny A. Higgins, PhD, MPH
University of Wisconsin, Madison

Kelsey Holt, ScD
University of California, San Francisco

Kristine Hopkins, PhD
University of Texas, Austin

Appendix

Elizabeth Janiak, ScD
Harvard University

Marian Jarlenski, PhD, MPH
University of Pittsburgh Graduate School of Public Health

Carole Joffe, PhD
University of California, San Francisco

Rachel K. Jones, PhD
Guttmacher Institute

Theodore Joyce, PhD
Baruch College and Graduate Center, City University of New York

Megan L. Kavanaugh, DrPH
Guttmacher Institute

Katrina Kimport, PhD
University of California, San Francisco

Kathryn Kost, PhD
Guttmacher Institute

Nancy Krieger, PhD
Harvard T.H. Chan School of Public Health

Kristin Luker, PhD
University of California, Berkeley

Appendix

Brenda Major, PhD
University of California, Santa Barbara

Deborah R. McFarlane, DrPH, MPA
University of New Mexico

Heidi Moseson, PhD, MPH
Ibis Reproductive Health

Caitlyn K. Meyers, PhD
Middlebury College

Suba Narasimhan, PhD
Emory University

Allison Norris, MD, PhD
Ohio State University

Jenny O'Donnell, ScD
Society of Family Planning

Joseph E. Potter, PhD
University of Texas at Austin

Lauren Ralph, PhD, MPH
University of California, San Francisco

Whitney S. Rice, DrPH
Emory University

Sarah C.M. Roberts, DrPH
University of California, San Francisco

Appendix

Corinne H. Rocca, PhD, MPH
University of California, San Francisco

Marjorie Sable, DrPH, MSW, MPH
University of Missouri, Columbia

Jessica Sanders, PhD, MSPH
University of Utah

John Santelli, MD, MPH
Columbia University Mailman School of Public Health

Johanna Schoen, PhD
Rutgers University, New Brunswick

Susheela Singh, PhD
Guttmacher Institute

Jody Steinauer, MD, PhD
University of California, San Francisco

Julia R. Steinberg, PhD
University of Maryland, College Park

Amanda Jean Stevenson, PhD
University of Colorado, Boulder

Andrea Swartzendruber, PhD, MPH
The University of Georgia

Terri-Ann Thompson, PhD
Ibis Reproductive Health

Janet Turan, PhD, MPH
University of Alabama at Birmingham, School of Public Health

Ushma D. Upadhyay, PhD, MPH
University of California, San Francisco

Kari White, PhD, MPH
University of Texas at Austin

Katie Woodruff, DrPH
University of California, San Francisco