No. 19-1392

IN THE

Supreme Court of the United States

THOMAS E. DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, *et al.*,

Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, *et al.*

Respondents.

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

BRIEF OF SOCIAL SCIENCE EXPERTS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici curiae are social science experts who have collectively spent decades conducting and publishing peer-reviewed research about the safety, incidence, social, psychological, and health impacts of unintended pregnancy and abortion in the United States. Their research has been published in hundreds of scientific articles which have appeared in leading medical and social science journals. In particular, their research focuses on the effects of state restrictions on women[2] seeking abortions. *Amici* include over 100 individuals who have authored studies on unwanted pregnancy and abortion in Mississippi and other restrictive settings as well as the consequences for families if abortion is no longer available.

Amici are therefore well-suited to assess the likely effects of abortion bans like Mississippi's statute, including the effect on women's health, well-being and socioeconomic outcomes. *Amici* have an interest in ensuring that robust scientific research is used to analyze evidence related to and impacts of laws that ban pre-viability abortion.

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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. The term "women" is used to reflect the participants as reported in many of the cited studies. However, *amici* recognize that trans men and non-binary people may become pregnant, seek abortion care and experience additional challenges in accessing care.

As *amici's* thorough research has shown, pre-viability abortion bans harm, rather than improve, people's health.

The full listing of 106 *amici* is attached as an appendix to this brief.

SUMMARY OF ARGUMENT

Mississippi passed House Bill 1510 that prohibits abortions, with limited exceptions, after 15 weeks of pregnancy (the "15-Week Ban"). After the district court enjoined the law, the Fifth Circuit Court of Appeals affirmed, finding that it is an unconstitutional ban on pre-viability abortions based on Supreme Court precedent dating back to *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Not only are these lower court decisions supported by decades of precedent, but scientific research amply demonstrates that Mississippi's 15-Week Ban would have significant negative consequences for women's physical, psychological, and socioeconomic well-being. *Amici* understand that if this Court does anything but affirm the Fifth Circuit's decision, that decision will be tantamount to overturning the central holdings of *Roe* and *Casey*. Dire consequences will follow: nearly half of the states in the United States are primed to ban abortion, millions of women will lose their constitutional right to determine whether they want to continue a pregnancy prior to viability, and they will also will lose access to legal and essential abortion care.

As demonstrated by the research cited herein, abortion is one of the most common and safe medical procedures performed in the United States. People who decide to terminate their pregnancy after 15 weeks of

pregnancy do not do so for frivolous reasons. Instead, they are often delayed in obtaining an abortion because of delays in recognizing they are pregnant, challenges raising funds, and logistical challenges related to locating a clinic or traveling to a clinic that will provide the services they seek. These delays are exacerbated in Mississippi which has only one abortion clinic in the entire state and where pre-existing regulations require, among other things, that patients make two trips to the clinic to obtain an abortion.

Mississippi's 15-Week Ban will make it more difficult for women to obtain abortion care, cause some women to unnecessarily delay their care, and for others, ultimately deny access to abortion care altogether. As a result, some may attempt to self-manage an abortion with potentially harmful or ineffective methods or carry the unwanted pregnancy to term, each scenario posing greater risks to people's health and well-being than having access to abortion services in clinics. In addition, social science research demonstrates that eliminating access to abortion has long-term negative socioeconomic consequences for women. Women who are denied an abortion are more likely to live below the poverty level and be unemployed years after being denied the abortion than women who receive their wanted abortion.

For these and the reasons set forth more fully below, *amici* urge this Court to affirm the court of appeal's decision.

ARGUMENT

I. Abortion Is A Very Safe, Common Medical Procedure.

Abortion is a very safe, common medical procedure, and part of the full spectrum of reproductive healthcare. Nearly one in four women will have an abortion in their lifetimes.[3] There is no typical abortion patient—abortion patients include people of every race, religion, age, and socioeconomic group, and the majority already have at least one child.[4] Yet, poor and low-income women are disproportionately represented among abortion patients, making up three quarters of those seeking abortion care.[5] In 2018, 4.7% of abortions nationally (more than 20,000) were performed after 15 weeks of pregnancy.[6]

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3. 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.

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

5. *Id*. at 7.

6. Katherine Kortsmit *et al*., *Abortion Surveillance - United States, 2018*, 69 Morbidity and Mortality Weekly Report 7, at 23 (Nov. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/ss/pdfs/ss6907a1-H.pdf ("Kortsmit, *Abortion Surveillance*").

Complication rates from abortion are very low.[7] Most abortion complications are minor, including easily treatable infections and incomplete medication abortions that later require aspiration.[8] Major complications are extremely rare, occurring at a rate of approximately 0.16% for first-trimester aspiration abortion and 0.41% for second-trimester or later abortion.[9]

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.[10] To put this

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7. *See e.g.* Diana Taylor *et al.*, *Standardizing the classification of abortion incidents: the Procedural Abortion Incident Reporting and Surveillance (PAIRS) Framework*, 96 Contraception 1, 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).

8. Upadhyay, *Incidence*, *supra* note 7, at 176, 181.

9. *Id.* at 176, 181 (defining "major complications" as "serious unexpected adverse events requiring hospital admission, surgery, or blood transfusion).

10. 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 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4554338/pdf/nihms718534.pdf ("Zane"); *see also* Kortsmit, *Abortion Surveillance*, *supra* note 6, at 7; Elizabeth G. Raymond and David

in context, a person is ten times more likely to be struck by lightning than to die from having an abortion.[11] For abortions performed between 14 and 17 weeks gestation, the mortality rate is 2.5 per 100,000 abortions.[12] For abortions performed at 18 weeks or later, the rate is 6.7 per 100,000 abortions.[13]

The physical health risks associated with childbirth are much greater than the risks associated with abortion: approximately 29% of hospital deliveries involve at least one obstetric complication,[14] compared to roughly 2% for abortion, which are primarily minor complications.[15] Overall,

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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").

11. *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%).

12. Zane, *supra* note 10.

13. *Id.* In comparison, in Mississippi, the death rate for drug overdoses is 13.6 per 100,000, for firearm injury it is 24.2 per 100,000, for homicide it is 15.4 per 100,000 and for COVID-19 it is 124.6 to 192.3 per 100,000. Centers for Disease Control and Prevention, Nat'l Center for Health Statistics, Mississippi, https://www.cdc.gov/nchs/pressroom/states/mississippi/ms.htm.

14. 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).

15. Upadhyay, *Incidence*, *supra* note 7, at 175.

abortion is approximately 14 times safer than carrying a pregnancy to term.[16] In Mississippi between 2013 and 2016, the pregnancy-related mortality ratio was 33.2 deaths per 100,000 live births, nearly double the national average.[17] There are also significant disparities in the state's maternal mortality rates. Black women in Mississippi are nearly three times more likely than white non-Hispanic women to die from pregnancy related causes.[18] If women are unable to access abortion and therefore must carry pregnancies to term, there will be a significant increase in exposure to these risks.

II. The Current Healthcare Landscape in Mississippi.

Mississippi lags the rest of the nation in access to healthcare, including access to contraception and abortion services. Mississippi has among the lowest public health spending per resident in the U.S.[19] Mississippi also has the highest rate of premature deaths and one of the highest rates of preventable hospitalizations in the U.S.[20]

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16. Raymond & Grimes, *supra* note 10, at 216.

17. *Mississippi Maternal Mortality Report 2013-2016*, Mississippi State Dep't of Health, at 5 (April 2019), https://msdh.ms.gov/msdhsite/_static/resources/8127.pdf ("Mississippi MMR").

18. *Id.*

19. *Commonwealth Fund 2020 Scorecard on State Health System Performance: Mississippi*, at 4 https://2020scorecard.commonwealthfund.org/files/Mississippi.pdf (Mississippi spends $15 on public health per resident whereas the national average is $37 per resident).

20. *America's Health Rankings Annual Report 2016*, United Health Found., at 58, 73 (2016), https://assets.americashealthrankings.org/app/uploads/ahr16-completerev.pdf.

Indicators of reproductive, maternal and child health in Mississippi are among the worst in the county and are getting worse. Mississippi has the highest rate of neonatal, infant and child mortality and one of the highest rates of preterm births and babies born with low birthweight and in the country.[21] Mississippi's maternal mortality rate, one of the highest in the country, has been climbing for more than a decade. From 2010 to 2012, the last measure, an average of nearly 40 women died for every 100,000 births.[22] The rate for Black women, 54.7, greatly exceeds the rate for white women, 29.3.[23]

Mississippi also lags in access to abortion. Jackson Women's Health Organization located in Jackson, Mississippi is currently the only remaining abortion facility in the state. Consequently, 81 out of Mississippi's 82 counties have no provider of abortion care and 91% of women in Mississippi live in a county without a provider.[24] The one remaining clinic has been the target of several recent laws in addition to the 15-Week Ban, including a ban on abortions after 6 weeks of

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21. *2016 Health of Women and Children Report: Mississippi*, America's Health Rankings, https://www.americashealthrankings.org/learn/reports/2016-health-of-women-and-children-report/state-summaries-mississippi.

22. Danielle Paquette, *Why Pregnant Women in Mississippi Keep Dying*, Washington Post (Apr. 24, 2015), https://www.washingtonpost.com/news/wonk/wp/2015/04/24/why-pregnant-women-in-mississippi-keep-dying/.

23. *Id.*

24. Rachel K. Jones, Elizabeth Witwer and Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. (Sept. 2019), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.

pregnancy[25] and a "trigger law" which imposes a criminal ban on all abortions and punishes clinicians with up to 10 years imprisonment for performing them, to be enforced if *Roe v. Wade* is ever reversed.[26] The Governor of Mississippi also announced that he would consider filing legislation to match a recent Texas law that authorizes private citizens to file lawsuits in state court against abortion providers and anyone involved in aiding abortion.[27]

The newest restrictions and laws (including the 15-Week Ban) follow more than two decades of various other regulations and efforts aimed at restricting access to abortion care. Mississippi bans telemedicine for medical care related to abortion[28] and mandates that each abortion provider provide information about the risks of abortion "orally and in person" to a patient seeking an abortion, after which the patient must wait 24 hours before returning to the clinic a second time to obtain the abortion (the "Mandatory 24-Hour Delay").[29] New research shows that the median interval between the consultation and abortion visit in 2019 in Mississippi was four days and that more than 30% of patients are not able to return for a week or more.[30] Other obstacles in Mississippi include

25. Miss. Code Ann. § 41-41-34.1.

26. Miss. Code Ann. § 41-41-45(4).

27. *GOP-Led States See Texas Law as Model to Restrict Abortions*, U.S. News (Sept. 2, 2021), https://www.usnews.com/news/politics/articles/2021-09-02/gop-led-states-see-texas-law-as-model-to-restrict-abortions ("U.S. News").

28. Miss. Code Ann. § 41-41-107.

29. Miss. Code Ann. § 41-41-33.

30. Klaira Lerma, Alexandra McBrayer, and Kari White,

burdensome facilities requirements that are not required for other office-based procedures[31] and a restriction that allows only physicians to provide abortion care.[32]

Not surprisingly, fewer Mississippi women obtain their abortion care in the state of Mississippi than elsewhere. In 2018, there were 5.1 abortions in Mississippi per 1,000 women of reproductive age, compared to 11.3 abortions per 1,000 reproductive-aged women nationally.[33] One study estimated a 11% decline in abortions in the six months after the Mandatory 24-Hour Delay law became effective, and a higher proportion of abortions terminated later in pregnancy.[34] Also, in the first year since the law went into effect, total resident abortions obtained outside

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Abortion Patients' Challenges Accessing Care in Mississippi, Mississippi Reprod. Health Access Project, The University of Texas at Austin, at 1 (Sept. 2021), https://sites.utexas.edu/msrepro/abortion-patients-challenges-accessing-care-in-mississippi/ ("Lerma, McBrayer & White").

31. Bonnie Scott Jones and Tracy A. Weitz, *Legal barriers to second-trimester abortion and public health consequences*, 99(4) Am. J. Pub. Health 623 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661467/.

32. Miss. Code Ann. § 41-75-1.

33. Kortsmit, *Abortion Surveillance*, *supra* note 6, at 14-15.

34. Frances A. Althaus and Stanley K. Henshaw, *The Effects of Mandatory Delay Laws on Abortion Patients and Providers*, 26(5) Family Planning Perspectives 228 (Sept.-Oct. 1994), https://www.jstor.org/stable/2135944 ("Althaus & Henshaw"); *see also* Theodore Joyce *et al.*, *The impact of Mississippi's mandatory delay law on abortions and births*, 278 J. Am. Med. Assoc. 653, 655 (1997) (concluding that in the year following the law, second-trimester abortions increased 4%).

of Mississippi increased by 6.8%.[35] In total, more than half of Mississippi residents who obtain abortion care travel out of state for services[36] and demand for online access to abortion pills was higher in Mississippi than any other state. From October 15, 2017, through August 15, 2018 there were 24.9 requests for medication abortion delivered through an online telemedicine service per 100,000 women of reproductive age in Mississippi.[37]

III. Women Seek Abortion Care, Including In The Second-Trimester, for a Variety of Reasons.

Women's reasons for seeking abortion include a range of personal and medical circumstances which do not differ by stage of pregnancy. The most common reasons for ending a pregnancy include concerns about economic security, the desire to finish an education, and responsibilities to current children or other family members.[38] Some of the delays in abortion access are

35. *Id.*

36. Tara C. Jatlaoui *et al.*, *Abortion Surveillance—United States, 2014*, 66 Morbidity and Mortality Weekly Report, at 20 (Nov. 24, 2017), https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6624-H.PDF.

37. Abigail R. A. Aiken, *et al.*, *Demand for Self-Managed Medication Abortion Through an Online Telemedicine Service in the United States*, 110(1) Am. J. Pub. Health 90, 93 (Jan. 2020), https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305369 ("Aiken, *Demand*").

38. Lawrence B. Finer *et al.*, *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Perspectives on Sexual and Reprod. Health 100, 114-115 (2005), https://www.guttmacher.org/sites/default/files/article_

attributable to Mississippi laws (discussed *supra*), that restrict access to abortion in the state and make it harder for people to access reproductive healthcare earlier in pregnancy.

Late recognition of pregnancy is one of the most common reasons why people are delayed in seeking abortion care. One study found that 58% of second-trimester abortion patients missed the opportunity to have a first-trimester abortion due to delays in suspecting and testing for pregnancy.[39] Delays in confirmation of pregnancy often can be attributed to uncertainty about the last menstrual period and an absence of pregnancy symptoms.[40] The majority of women (64%) who get abortions were using a method of contraception in the month they conceived[41] and recent research has shown

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files/3711005.pdf; M. Antonia Biggs, Heather Gould and Diana Greene Foster, *Understanding why women seek abortions in the US*, 13(29) BMC Women's Health (2013), https://bmcwomenshealth.biomedcentral.com/track/pdf/10.1186/1472-6874-13-29.pdf ("Biggs, *Understanding*").

39. Eleanor A. Drey *et al.*, *Risk Factors associated with presenting for abortion in the second trimester*, 107(1) Obstetrics & Gynecology 128, 133 (Jan. 2006) ("Drey, *Risk Factors*"); *see also* Lawrence B. Finer *et al.*, *Timing of steps and reasons for delays in obtaining abortions in the United States,* 74 Contraception 334, 338 (2006) ("Finer, *Timing*") (finding that problems suspecting or confirming pregnancy were key factors in obtaining abortions in the second-trimester).

40. Drey, *Risk Factors*, *supra* note 39, at 133; Diana Greene Foster *et al.*, *Predictors of delay in each step leading to an abortion*, 77 Contraception 289, 290 (2008) ("Foster, *Predictors*").

41. Diana Greene Foster, Heather Gould and M. Antonia Biggs, *Timing of Pregnancy Discovery Among Women*

that use of contraception leads to delay in recognition of pregnancy because the woman thought she was protected from the risk of pregnancy and because many contraceptive methods have side effects (e.g., cessation of menstrual periods) that are similar to pregnancy symptoms.[42] When a woman is late in realizing she is pregnant, the logistical barriers become much greater, resulting in further delays.[43] In particular, it is common for young people to experience a delayed recognition of their pregnancy.[44] Young people are also more likely to experience an unplanned pregnancy.[45] Consequently, teenagers and women in their early twenties were more likely than older women to have an abortion in the second-trimester.[46]

Seeking Abortion, Contraception, at 4 (Aug. 4, 2021), https://www.contraceptionjournal.org/article/S0010-7824(21)00344-9/fulltext#relatedArticles.

42. *Id*. at 5.

43. Ushma D. Upadhyay *et al*., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104(9) Am. J. Pub. Health 1687, 1692 (Sept. 2014) ("Upadhyay, *Denial*").

44. Finer, *Timing*, *supra* note 39, at 338 (finding people under the age of 18 took longer to acknowledge pregnancy symptoms and take a pregnancy test).

45. Lawrence B. Finer and Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, N. Engl. J. Med. 843 (March 3, 2016), https://www.nejm.org/doi/full/10.1056/nejmsa1506575.

46. Diana Greene Foster and Katrina Kimport, *Who seeks abortions at or after 20 weeks?,* 45(4) Perspectives on Sexual and Reprod. Health 210, 212 (2013).

Costs also play a significant factor in delaying abortion care. People who have an abortion during the second-trimester often cite as cause for delay difficulty raising funds for an abortion because they cannot use their health insurance,[47] or finding an insurance provider to cover the procedure.[48] Accordingly, many people who have abortions in the second-trimester are economically disadvantaged.[49]

These burdens are particularly acute in Mississippi, where almost a quarter of all working-age women (between the ages of 18 and 64) live below the poverty line—the highest percentage of women living below the poverty line in the nation.[50] For people struggling just to feed their families, any additional costs created by Mississippi's

47. Jessica W. Kiley *et al.*, *Delays in request for pregnancy termination: comparison of patients in the first and second trimesters*, 81 Contraception 446, 449-450 (2010) ("Kiley, *Delays*"); Sarah C.M. Roberts *et al.*, *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24(2) Women's Health Issues e211, e215 (2014); Uphadyay, *Denial*, *supra* note 43, at 1692 ("Once a woman is beyond the first trimester, raising the funds to pay for the abortion can lead to further delays and create a cycle of increasing cost and delay.").

48. Finer, *Timing*, *supra* note 39, at 341-42.

49. Alexa L. Solazzo, *Different and Not Equal: The Uneven Association of Race, Poverty and Abortion Laws on Abortion Timing*, 66 Soc. Problems 519, 522 (2019) ("Poor women are more likely to be delayed in accessing an abortion than non-poor women, and financial barriers contribute to the delay in one-fifth of second trimester abortions, with uninsured women having over six times higher odds of reporting difficulties in payment for delaying abortion compared to insured women.").

50. Talk Poverty, Mississippi 2020, https://talkpoverty.org/state-year-report/mississippi-2020-report/.

abortion restrictions, let alone an abortion ban, can make abortion care prohibitively expensive. One study found that for households in Mississippi earning the state's median monthly income, the cost for a second-trimester abortion exceeds the total of all non-subsistence income by $427.[51] And while the medical profession recognizes that abortion is an important component of people's health and reproductive healthcare, many people in Mississippi do not have insurance that covers abortion care because Mississippi law prohibits health insurance purchased through the state exchange and Medicaid from covering abortion care except in very limited circumstances.[52] Thus, the majority of people in Mississippi must pay for abortion care out-of-pocket.[53]

The logistics of finding a clinic to perform the abortion as well as arranging for child care during the procedure and funding costs to travel to the clinic are also reasons

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51. Carmela Zuniga, Terri-Ann Thompson, Kelly Blanchard, *Abortion as a Catastrophic Health Expenditure in the United States*, 30(6) Women's Health Issues 416 (Nov.-Dec. 2020), https://www.sciencedirect.com/science/article/pii/S1049386720300669.

52. *See* Miss. Code Ann. § 41-41-99; *see also State Facts About Abortion: Mississippi*, Guttmacher Inst. (Jan. 2021), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-mississippi.

53. *See* Kari White *et al.*, *Women's post-abortion contraceptive preferences and access to family planning services in Mississippi*, 30(3) Women's Health Issues 176, 179 (2020), http://sites.utexas.edu/txpep/files/2020/02/White-et-al-Postabortion-Contraceptive-Preferences-Mississippi-WHI-2020-in-press.pdf (finding that 70% of Mississippi abortion patients said it was somewhat/very difficult to cover the cost of their abortion).

for delay in obtaining an abortion.[54] Travel of even short distances can present significant obstacles as people must find or save money for the cost of transportation and other travel-related expenses and potentially take time off from work.[55] These logistical issues are exceptionally common in Mississippi because there is only one abortion clinic and the Mandatory 24-Hour Delay Law requires two trips to that clinic.[56] Many people must also find child care—not once but twice—as 68% of the people in Mississippi who have an abortion at the clinic already have at least one child.[57] In fact, a 2019 survey of over 200 people who had abortions at the Jackson clinic shows that 57% of respondents had to miss work to attend an abortion visit, 34% had to make child care arrangements

54. Drey, *Risk Factors*, *supra* note 39, at 130 ("Subjects in the second trimester were more likely to have been referred from other clinics and to have had difficulty finding an abortion provider."); Kiley, *Delays*, *supra* note 47, at 449-50; Jill Barr-Walker *et al.*, *Experiences of women who travel for abortion: A mixed methods systematic review*, 14(4) PLOS ONE, at 17 (April 9, 2019), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0209991 ("the limited availability of abortion providers, insurance restrictions, as well as gestational age and other legal restrictions result in women needing to travel long distances for abortion services, often crossing state or country borders to seek care."); Heidi Moseson *et al.*, *Self-managed abortion: A systematic scoping review*, 63 Best Practice & Res. Clinical Obstetrics and Gynecology 87, 101 (2020).

55. Daniel Grossman *et al.*, *Factors associated with delays obtaining abortion care in Texas*, 102 Contraception 288 (2020), https://www.sciencedirect.com/science/article/abs/pii/S0010782420302572?via%3Dihub.

56. *See* Miss. Code Ann. §§ 41-41-33.

57. Kortsmit, *Abortion Surveillance*, *supra* note 6, at 21.

and 43% had to travel 50 miles or more one way to get to the clinic.[58] The burdens caused by these delays in access to abortions are magnified for those who are economically disadvantaged, which make up 75% of the people who have abortions nationally.[59]

Access to abortion beyond 15 weeks is also important for women who are faced with a fetal diagnosis of major anatomic or genetic anomalies.[60] Multiple studies have found that between 45% and 80% of patients with a fetal diagnosis decided to terminate their pregnancy.[61] Even if the initial diagnosis of a fetal anomaly is made in the first-trimester, many people often have a follow up

58. Lerma, McBrayer & White, *supra* note 30, at 1.

59. *See* Caitlin Myers, Rachel Jones and Ushma Upadhyay, *Predicted changes in abortion access and incidence in a post-Roe world*, 100 Contraception 367, 372 (2019) ("Myers, *Predicted Changes*").

60. Lori M. Gawron *et al.*, *An exploration of women's reasons for termination timing in the setting of fetal abnormalities*, 88 Contraception 109 (2013); Kelli Stidham Hall *et al.*, *Abortion trends in Georgia following enactment of the 22-week gestational age limit, 2007–2017*, 110(7) Am. J. Pub. Health 1034 (July 2020) ("Another group of patients who seek abortion after 20 weeks are those diagnosed with severe fetal abnormalities, most of whom choose to terminate their pregnancies; denying abortion services for those patients carries important and harmful implications for maternal-infant morbidity and mortality.").

61. Nigel Anderson, Owen Boswell and Gerald Duff, *Prenatal Sonography for the Detection of Fetal Anomalies: Results of a Prospective Study and Comparison with Prior Series*, 165 Am. J. Roentgenol 943, 948 (1995), https://www.ajronline.org/doi/pdf/10.2214/ajr.165.4.7676997 (finding termination in 45% of cases); Gawron, *supra* note 60, at 109 (finding termination in 80% of cases).

consultation with their physician after an initial diagnosis and then need additional time to consider and make the decision, thereby pushing the abortion later into the second-trimester.[62]

IV. Mississippi's 15-Week Ban Will Have Devastating Effects on Women and Families.

A large prospective longitudinal study examining the effects of abortion and abortion denial on the socioeconomic, physical and mental well-being of women demonstrates that being denied a wanted abortion has devastating effects on women and families. Known as the "Turnaway Study," this national study compared a variety of outcomes for women who received abortions later in pregnancy with those who sought but were denied abortions because their pregnancies were beyond the gestational age cut-off at the facility where they sought care.[63] The study followed nearly 1,000 women for five years. Over 40 researchers—epidemiologists, demographers, sociologists, economists, psychologists, statisticians, nurses, public health scientists, and physicians—collaborated to carry out the Turnaway Study.

The findings from the Turnaway Study have been comprehensively vetted by the scientific community, as evidenced by the more than 50 articles published in high

62. *Id.* at 111-113.

63. Diana Greene Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having—or Being Denied—an Abortion* (Scribner, June 2, 2020).

impact peer-reviewed scientific journals.[64] According to the National Academies of Sciences, Engineering and Medicine report on the safety of abortion, the Turnaway Study "contributes unique insight into the consequences of receiving a desired abortion versus being denied the procedure and carrying the pregnancy to term."[65] The study provides the most recent and rigorous evidence on the consequences of denying women a wanted abortion due to gestational age cutoffs in the U.S. The study's notable strengths include its longitudinal design, adjustment for cofounders, and use of appropriate comparison groups. Those receiving abortions were compared with those denied abortions; the two groups were similar at the time of seeking an abortion. Therefore, their subsequent differences in outcomes demonstrate the impact of being denied an abortion due to gestational age cutoffs.

As addressed below, the Turnaway Study and other peer-reviewed studies that have followed demonstrate that being denied an abortion negatively impacts all areas of a woman's life.

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64. Researchers who conducted the study published 50 articles in top medicine, psychology, public health and sociology journals, such as the American Journal of Public Health, Annals of Internal Medicine, JAMA Psychology, JAMA Pediatrics and Social Science & Medicine. Each article was reviewed by two to three experts selected by the editor of the journal and the authors had to address all their questions and critiques before the papers were accepted by each journal.

65. Nat'l Acad. of Sci., Eng'g, and Med., *The Safety and Quality of Abortion Care in the United States*, The Nat'l Acad. Press, at 151 (2018), https://dktwomancare.org/pdfresources/The%20Safety%20and%20Quality%20of%20Abortion%20Care%20in%20the%20United%20States.pdf ("NASEM Study").

A. Banning Abortions After 15 Weeks Will Force People to Travel Out-of-State, Increase Costs and Prevent Some From Accessing Abortions At All.

If the 15-Week Ban goes into effect, many in Mississippi will be forced to travel out-of-state for abortion care after 15 weeks, and others will be denied access to care entirely. Because marginalized populations, such as people of color and those having difficulty making ends meet are already more likely to be delayed in seeking abortion services,[66] these obstacles may make it even more difficult, or impossible, for them to obtain abortion care in any state.[67] According to a national study, "in 2008 more than 4000 women carried unwanted pregnancies to term after they were denied an abortion because of provider gestational age limits."[68] This experience is likely more common in states, such as Mississippi, which have more restrictions on abortion and poorer access to abortion services.

The 15-Week Ban will result in in women seeking abortion care in neighboring states where access is already difficult. For example, in Louisiana, abortion patients reported traveling between one to three hours to obtain care at one of the state's three clinics and were

66. 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, at 11-13 (2017), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0169969.

67. *Id.*

68. Upadhyay, *Denial*, *supra* note 43, at 1692.

often forced to wait more than a week for the next available appointment.[69] Moreover, given that many neighboring states are poised to implement similar or earlier abortion bans, people in Mississippi will likely need to travel across multiple state lines to obtain an abortion if the 15-Week Ban is upheld.[70]

There are many logistical challenges and costs associated with the need to travel across multiple state lines to obtain an abortion, including transportation costs, arranging childcare and taking time off of work.[71] If these costs or logistical challenges are too great for people to be able to travel out of state for an abortion (which is more likely for those who are economically disadvantaged), women in Mississippi will be entirely denied access to the care they need.[72]

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69. Erin Carroll and Kari White, *Abortion patients' preferences for care and experiences accessing services in Louisiana*, Contraception (2020), https://www.researchgate.net/publication/337595161_Abortion_patients'_preferences_for_care_and_experiences_accessing_services_in_Louisiana; *see also* Kari White *et al.*, *Experiences Accessing Abortion Care in Alabama among Women Traveling for Services*, 26(3) Women's Health Issues 298 (2016) (discussing difficulties of obtaining an abortion in Alabama).

70. *See* Myers, *Predicted Changes, supra* note 59, at 368 (listing Alabama, Louisiana, Arkansas, and Tennessee as among those states with trigger bans or pre-*Roe* bans).

71. *See* Althaus & Henshaw, *supra* note 34, at 231, 233.

72. Upadhyay, *Denial*, *supra* note 43, at 1692.

B. Denying Access to Abortion Negatively Affects Women's Physical and Mental Health.

Contrary to the State's asserted interests supporting the 15-Week Ban, denying access to abortion will *not* improve women's physical or mental health outcomes. It will have the opposite effect.

First, because not all pregnant women will be able to travel out-of-state to access abortion, the 15-Week Ban may cause more people to attempt to self-manage their abortions.[73] A common reason people attempt to self-manage their abortions is because they do not have the money to travel to or pay for clinic-based care.[74] Consequently, the prevalence of self-managed abortions may be highest amongst people who are economically

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73. *See* Abigail R.A. Aiken, *et al.*, *Motivations and Experiences of People Seeking Medication Abortion Online in the United States*, 50(4) Perspectives on Sexual and Reprod. Health 157, 161 (2018) ("Aiken, *Motivations*"); *see also* Abigail R.A. Aiken *et al.*, *Demand for Self-Managed Online Telemedicine Abortion in the United States During the Coronavirus Disease 2019 (COVID-19) Pandemic*, 136(4) Obstetrics & Gynecology 835, 837 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7505141/ ("Among states that limited access to in-clinic abortion during the pandemic, we observed larger increases in requests [for self-managed abortion] in states with the most severe and longest lasting restrictions.").

74. *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 ("*Texas Women*"); *see also* Aiken, *Motivations*, *supra* note 73, at 161.

disadvantaged.[75] While some women may be able to safely and effectively self-manage their own abortions with abortion pills they obtain online,[76] self-management, especially through methods other than abortion pills, may be less effective and less safe, resulting in delay seeking effective abortion care, and all methods used to self-manage abortion carry legal risks.[77] Women across the South, where access to legal abortion is particularly restricted, are already attempting to self-manage their

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75. Lauren J. Ralph *et al.*, *Prevalence of Self-Managed Abortion Among Women of Reproductive Age in the United States*, 3(12) JAMA Network Open, at 7 (Dec. 18, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774320 ("Ralph, *Prevalence*"); Liza Fuentes *et al.*, *Texas women's decisions and experiences regarding self-managed abortion*, 20(6) BMC Women's Health, at 11 (2020), https://doi.org/10.1186/s12905-019-0877-0 ("We suspect that self-managed abortion may become more common if clinic-based abortion care becomes more difficult to access, especially . . . among poor women—who make up more than half of all abortion patients and face barriers to accessing reproductive healthcare.").

76. 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. *See* Jerman, Jones & Onda, *Characteristics*, *supra* note 4, at 8.

77. 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/S0968-8080%2810%2936534-7?needAccess=true (discussing medical and legal risks associated with self-induced abortion); Sarah Raifman *et al.*, *"I'll just deal with this on my own": a qualitative exploration of experiences with self-managed abortion in the United States*, 18(91) Reprod. Health, at 9-10 (May 2020), https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-021-01142-7 ("Raifman").

abortions,[78] some with safer and effective options such as medication abortion pills and others using harmful options.[79]

Restricting access also can put abortion completely out of reach for many people, thereby forcing women to carry an unwanted pregnancy to term.[80] This too increases the risk of complications, injury and death, as a woman is fourteen times more likely to die from giving birth than as a result of an abortion.[81] This risk is exacerbated in Mississippi where the pregnancy-related

78. *Texas Women*, *supra* note 74, at 1 (2012 study of women in Texas found that 7% "reported having attempted to self-induce abortion for their current pregnancy").

79. Aiken, *Demand*, *supra* note 40, at 93; Ralph, *Prevalence*, *supra* note 75, at 12; Raifman, *supra* note 77, at 8-9.

80. Joanna Venator and Jason Fletcher, *Undue Burden Beyond Texas: An Analysis of Abortion Clinic Closures, Births, and Abortions in Wisconsin*, 40(3) J. Pol'y Analysis and Mgmt. 774 (2021) (in study of Wisconsin following clinic closures, researchers 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(5) Contraception 496 (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; Jason M. Lindo *et al.*, *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions,* J. Human Res. (May 6, 2019).

81. *See* Raymond & Grimes, *supra* note 10, at 216.

deaths are almost twice the average rate in the U.S.[82] And pregnancy-related deaths are nearly three times higher among Black people than White people in Mississippi.[83]

The physical health risks of childbirth versus abortion is demonstrated in the Turnaway Study where women who carried pregnancies to term were much more likely to experience life threatening complications[84] and two women died of childbirth-related causes after being denied a wanted abortion.[85] Women denied abortions also experience worse physical health over five years, compared to women who received a wanted abortion, including higher rates of chronic pain and hypertension.[86] 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 those who are able to receive a wanted abortion.[87]

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82. Mississippi MMR, *supra* note 17, at 5 ("From 2013 to 2016, 136 Mississippi women died due to pregnancy-related causes.").

83. *Id.*

84. Caitlin Gerdts, *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26(1) Women's Health Issues 55, 59 (2016), https://www.sciencedirect.com/science/article/pii/S1049386715001589.

85. 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, 245 (2019), https://www.redaas.org.ar/archivos-recursos/470-Ralph%202019_Self-reported%20physical%20health%20of%20women%20who%20did%20and%20did%20%20not%20terminate%20pregnancy.pdf.

86. *Id.* at 244.

87. Sarah C.M. Roberts *et al.*, *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied*

Reducing access to abortion has no positive effect on people's mental health and emotional well-being. Recent studies and systematic 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 people's mental health.[88] Research shows that having an abortion does not lead to increased likelihood of depression, anxiety, post-traumatic stress or of suicidal ideation compared to carrying an unwanted pregnancy to term.[89] Soon after seeking abortion and

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an Abortion, 12(144) BMC Med., at 5 (2014), https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-014-0144-z.

88. Vignetta E. Charles *et al.*, *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78(6) Contraception 436 (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 (Feb. 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 (Dec. 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 90-91 (2008), https://www.apa.org/pi/women/programs/abortion/mental-health.pdf; NASEM Study, *supra* note 65, at 149-152.

89. 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.")

over time, women have more positive emotions about their abortion than negative ones,[90] with relief being the most common response.[91] The Turnaway 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 five years following her abortion.[92]

There is, however, evidence that barriers to abortion access can have a negative impact on people's mental health and well-being. Women experiencing barriers accessing abortion care and those denied abortion care

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

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

91. 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 Reprod. Health 122 (2013) ("Rocca, *Women's Emotions*"); Corrine Rocca *et al.*, *Emotions and decision rightness over five years following an abortion: An examination of decision difficulty and abortion stigma*, 248 Soc. Sci. & Med., at 7 (March 2020), https://www.sciencedirect.com/science/article/pii/S0277953619306999 ("Rocca, *Emotions*").

92. Rocca, *Decision Rightness*, *supra* note 90, at 7; *see also* Rocca, *Women's Emotions, supra* note 91, at 122.

have increased negative mental health symptoms in the short-term.[93] For example, approximately one week after seeking an abortion, people who are denied abortions because of gestational age limits are more likely to report symptoms of anxiety, stress[94] and low self-esteem than people who receive an abortion.[95] Women seeking later abortions did not experience more symptoms or cases of depression, anxiety, post-traumatic stress, or suicidal ideation than people obtaining a first-trimester abortion.[96] There is thus no basis to conclude that abortion bans like Mississippi's 15-Week Ban improve women's mental or physical health.

C. Abortion Bans Have Negative Socioeconomic Effects on Women and their Children.

The most common reasons people seek abortions are socioeconomic—not having the resources to nurture a new baby.[97] In the Turnaway Study, 40% of women seeking

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93. Biggs, *Mental Health*, *supra* note 89, at 174; M. Antonia Biggs *et al.*, *Developing and validating the Psychosocial Burden among people Seeking Abortion Scale (PB-SAS)*, 15(12) PLOS ONE (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7728247/.

94. Laura F. Harris, *Perceived stress and emotional social support among women who are denied or receive abortions in the United States: a prospective cohort study*, 14(76) BMC Women's Health, at 6 (2014), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-14-76.

95. Biggs, *Mental Health*, *supra* note 89, at 173-74.

96. *Id.* at 174-76.

97. Sophia Chae, *Reasons why women have induced abortions: a synthesis of findings from 14 countries*, 96

abortion 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 concerns about employment.[98] Further, approximately 60% of abortion patients already have children,[99] and nearly one-third of people seeking an abortion say that their reason for wanting an abortion is to care for the children they already have.[100]

Research confirms that people's concerns about their ability to provide for a child are well-founded. The Turnaway Study found that women denied a wanted abortion were less financially secure in subsequent years than those who received an abortion.[101] Six months after seeking an abortion, women who were denied an abortion

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Contraception 233, 237 (2017), https://www.contraceptionjournal.org/article/S0010-7824(17)30188-9/fulltext; Biggs, *Understanding*, *supra* note 38, at 4-8.

98. *Id*. at 5.

99. Jerman, Jones & Onda, *Characteristics*, *supra* note 4, at 1.

100. 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*").

101. 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").

were more likely than those similarly situated who had obtained an abortion to be receiving temporary assistance for needy families (TANF) (15% vs less than 8%), more likely to receive food assistance (SNAP) (44% vs 33%), more likely to be living below the poverty level (61% vs 45%) and less likely to be employed full time (30% vs 40%).[102] In addition, being denied an abortion increases the chances that a woman's existing children live in poverty.[103] Being able to delay the birth of a subsequent child increases the probability that the next child is intended[104] and lives in economic security.[105] Other Turnaway analyses 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.[106] Other research has found that young people who chose to have

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102. *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]").

103. Foster, *Effects*, *supra* note 100, at 185.

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

105. 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.

106. 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.

an abortion were ultimately better off economically and educationally than their peers who carried to term.[107]

Differences in credit scores confirm study participants' reports of financial harm from carrying an unwanted pregnancy to term: women who were turned away experienced higher debt and a lowering of their credit scores that lasted for years, further demonstrating the economic harm of being denied an abortion.[108] Imposing more widespread gestational limits on abortion will have long-lasting and large effects on women's economic well-being.

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 well-being.

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107. Laurie Schwab Zabin *et al.*, *When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy*, 21 Family Planning Perspectives 248, 254 (1989); Molly A. McCarthy *et al.*, *The effect of receiving versus being denied an abortion on making and achieving aspirational 5-year life plans*, BMJ Sexual Reprod. Health, at 6 (2020); Lauren J. Ralph *et al.*, *A Prospective Cohort Study of the Effect of Receiving versus Being Denied an Abortion on Educational Attainment*, Women's Health Issues (2019).

108. Sarah Miller, Laura R. Wherry and Dianna Greene Foster, *The Economic Consequences of Being Denied an Abortion*, Nat'l Bureau of Econ. Res., Working Paper 26662, at 29 (Jan. 2020), https://www.nber.org/system/files/working_papers/w26662/w26662.pdf.

D. If the 15-Week Ban is Upheld, Access to Abortion Care Will be Decimated for Half of the United States.

The 15-Week Ban deprives people from accessing abortion care months prior to viability. Not only is the 15-Week Ban therefore violative of this Court's precedents, nearly half of the states in this country (22 states, home to 41% of women of childbearing age) are poised to ban abortion if the ban is upheld and *Roe v. Wade* is overturned, in whole or in part.[109] These states are predominately located in the South and Midwest and include a large population of economically disadvantaged residents.[110] Additionally, at least half a dozen states are considering copying the recent Texas abortion statute that enables private citizens to file lawsuits against abortion providers and others.[111] There can be no doubt that this Court's consideration of Mississippi's House Bill 1510 will have dramatic consequences for people across the country.

The combined effect of the anti-abortion legislation would be devastating to women's access to reproductive health services. If abortion facilities in these states close, the distances women will need to travel to obtain

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109. *Abortion Policy in the Absence of Roe*, Guttmacher Inst. (Sept. 1, 2021), https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe; Quoctrung Bai, Claire Cain Miller and Margot Sanger-Katz, *Where Abortion Access Would Decline if Roe v. Wade Were Overturned*, N.Y. Times (May 18, 2021), https://www.nytimes.com/interactive/2021/05/18/upshot/abortion-laws-roe-wade-states.html ("N.Y. Times").

110. *Id.*; Myers, *Predicted Changes*, *supra* note 59.

111. *See* U.S. News, *supra* note 27.

the abortion they seek will dramatically increase, from an average of 35 miles to 279 miles.[112] "Women who can't afford to travel to a legal clinic or leave work for the trip" will be the most heavily impacted.[113] As a result, "legal abortion access could effectively end for those living in much of the American South and Midwest, especially those who are poor[.]"[114] If Mississippi's 15-Week Ban is upheld, it undoubtedly will result in increasing delay and burden for people seeking abortion services, ultimately denying many their wanted abortion.

112. N.Y. Times, *supra* note 109.

113. *Id.*

114. *Id.*

CONCLUSION

Decades of rigorous social science research have made clear the detrimental short and long-term effects on the physical, psychological, financial, and emotional well-being of women and their families that will result if the 15-Week Ban is upheld. For these, and the foregoing reasons discussed herein, *amici* respectfully urge this Court to affirm the Court of Appeal's decision.

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