No. 19-1392

IN THE Supreme Court of the United States

THOMAS E. DOBBS, M.D., M.P.H., in his Official Capacity as State Health Officer of the Mississippi Department of Health, et al.,
Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, on Behalf of Itself and Its Patients, et al.,
Respondents.

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

BRIEF OF LOCAL GOVERNMENTS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST

Amici are cities and counties from across the country.[1] Some *Amici* are in states with laws that significantly restrict abortion access, while others are in states with broader access. Some *Amici* deliver health care services directly (including by performing abortions in city or county facilities), serving as the health care providers of last resort. Other *Amici* focus on more general public health initiatives, such as by providing information and resources. We file this brief to highlight the shared interest and responsibility of local governments in protecting the health, safety, and general welfare of all our constituents, including through closing racial and economic inequalities in health care access, health outcomes, and economic opportunity—inequities that abortion restrictions greatly compound. To adequately address the public health needs in our communities, we all rely on the existing viability standard guaranteeing a woman's right to an abortion under the Constitution.

Cities and counties stand on the frontlines of our nation's struggles with racial and income inequality. Local governments provide the essential services and programs that are the building blocks of our communities. We educate our children, care for our

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[1] All parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund its preparation or submission. No person other than *Amici* or *Amici*'s counsel made a monetary contribution to the preparation or submission of this brief. A list of all *Amici* is available at Appendix A.

sick, and maintain the safety of our neighborhoods. We also contend with the consequences of intentional action (and inaction) by local governments over the course of our nation's history that have contributed to racial discrimination, disparities in opportunity, and systematic oppression. Those consequences include deep and extensive multi-generational harm to people of color and other historically underrepresented, marginalized, and disenfranchised groups.

Despite having one of the best health care and public health systems in the world, our country still sees significant differences in morbidity and mortality rates based on a person's race, means, location, and social status—indeed, the federal government recognizes structural and individual discrimination as key determinants of public health outcomes.[2] These factors impact outcomes for all forms of care, including and especially for reproductive health, where women of color and their children experience relatively worse outcomes.

Many local governments have taken steps to combat these endemic challenges, including by naming racism a public health crisis.[3] Many have

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[2] Office of Disease Prevention & Health Promotion, *Discrimination, Healthy People 2020*, Dep't of Health & Hum. Servs., https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/discrimination.

[3] At least 106 city councils, 78 county boards, and 16 mayors have passed resolutions or issued declarations stating that racism is a public health crisis. Cliff Despres, *Update: 231 Cities, Counties, Leaders Declare Racism a Public Health Crisis!*, Salud America! (Dec. 7, 2020) (last updated Aug. 6, 2021), https://salud-america.org/rising-number-of-cities-counties-are-declaring-

implemented programs specifically focused on low-income women and Black women. *Amici* know from experience that their work requires purposeful planning and determined efforts to make even small differences.

The arguments advanced by Petitioners in this case threaten *Amici*'s crucial work and must be viewed in that light. As local governments seek to bridge the racial and socioeconomic disparities in reproductive care, they cannot afford further obstacles to be placed in the way of abortion access. The right first recognized in *Roe v. Wade*, 410 U.S. 113 (1973), and later affirmed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), established a baseline guarantee of abortion access upon which localities depend as they tailor their approaches to bridging reproductive health gaps. If this baseline protection is eliminated, women of color and low-income women will be disproportionately affected, setting back these local government efforts.[4] *Amici* write to ensure that the Court accounts for all reliance interests when evaluating the *stare decisis* factors, which clearly dictate affirmance in this case.

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racism-a-public-health-crisis/; *see also Racism Is a Public Health Crisis*, Am. Pub. Health Ass'n, https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations.

[4] Although the term "women" is used herein, *Amici* recognize that transgender men and nonbinary persons also may become pregnant.

SUMMARY OF ARGUMENT

For nearly 50 years, this Court's precedent has established a baseline guarantee of pre-viability abortion access for women nationally. Preservation of this right has been crucially important to the health and economic well-being of millions of women, their families, and their communities. The viability standard that this Court has maintained from the time women of childbearing age were born promotes equity by allowing sufficient time into pregnancy for women to make considered decisions and access care. If this Court were to allow Mississippi's pre-viability ban, Miss. Code Ann. § 41-41-191 (the "Mississippi Ban"), to take effect, it would significantly curtail the scope of that right and exacerbate existing racial and socioeconomic discrimination and further deepen health disparities.

Amici, as local governments, are a critical part of the fight against racial and socioeconomic health disparities that affect people of color and lower-income people in our communities. Among *Amici*'s areas of focus is reproductive health, an area where racial and socioeconomic health disparities prove most stark.

The Mississippi Ban would exacerbate already acute health disparities. It would disproportionately cause women of color and low-income women to lose access to abortions because they, as a group, have abortions later than White and higher-income women. A decision upholding the ban would create legal chaos not only in Mississippi, but nationwide, because it could trigger even more restrictive abortion bans in Mississippi and in many other states. Our nation's

experience prior to *Roe v. Wade*, as well as evidence from the impact of prior abortion restrictions, makes it abundantly clear that women with means would continue to have access to abortion while other women (typically women of color and lower-income women) would lose that access, worsening negative health outcomes and economic vulnerabilities. Such an outcome would work at cross-purposes to the crucial efforts undertaken by local governments nationwide to combat endemic disparities in our public health system.

ARGUMENT

I. ERADICATING RACIAL AND ECONOMIC HEALTH DISPARITIES IS A CORE PRIORITY FOR LOCAL GOVERNMENTS

Local governments are deeply committed to addressing health disparities—inequities between groups with respect to health (*e.g.*, disease incidence), health care (*e.g.*, access to physicians and other providers), and health outcomes (*e.g.*, mortality).[5] Health disparities in America, including those in reproductive health, are well documented and well recognized.[6] As the National Institute on Minority

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[5] *Health Disparities Overview*, Nat'l Conf. of State Legislatures (May 10, 2021), https://www.ncsl.org/research/health/health-disparities-overview.aspx.

[6] Zinzi D. Bailey et al., *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 Am. Eq. & Equal. in Health, p. 1453 (2017), https://med.emory.edu/departments/human-genetics/dei/documents_images/documents/lancet_2017_structural-racism-and-health-inequities.pdf ("Racial and ethnic inequalities, including health inequities, are well documented in the USA[.]"); Wayne J. Riley, *Health Disparities: Gaps in Access,*

Health and Health Disparities observed, "[w]hile the diversity of the American population is one of the nation's greatest assets, one of its greatest challenges is reducing the profound disparity in health status of its racial and ethnic minority, rural, low-income, and other underserved populations."[7]

Amici have undertaken extensive programming, especially in recent years, to address these disparities, as discussed below.

A. Racial and Socioeconomic Disparities Are Especially Pronounced in the Area of Reproductive Health

When addressing issues of reproductive health, this Court must confront the reality that race is among the strongest predictors of outcomes.[8] Racial health

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Quality and Affordability of Medical Care, 123 Trans. Am. Clinical & Climatological Ass'n (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540621/ ("As a complex and multi-factorial construct, differential access to medical care, treatment modalities, and disparate outcomes among various racial and ethnic groups has been validated in numerous studies.").

[7] *Overview,* Nat'l Inst. on Minority Health & Health Disparities (last updated May 5, 2021), https://www.nimhd.nih.gov/about/overview/.

[8] A. Baciu et al. eds., *The State of Health Disparities in the United States*, Communities in Action: Pathways to Health Eq., ch. 2 (2017), https://www.ncbi.nlm.nih.gov/books/NBK425844/ ("Racial and ethnic disparities are arguably the most obstinate inequities in health over time, despite the many strides that have been made to improve health in the United States."); Cristina Novoa & Jamila Taylor, *Exploring African Americans' High Maternal and Infant Death Rates*, Ctr. Am. Progress (Feb. 1, 2018), https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-

disparities are "persistent and difficult to address."[9] Similarly, and often relatedly, differences in socioeconomic status—whether related to income, education, or occupation—"persist[] across the life cycle and across measures of health."[10] Simply put: "Those with higher incomes are more likely to live longer, healthier lives."[11]

The COVID-19 pandemic highlights the health inequities suffered by diverse populations, inequities that local governments are often in the best position to address. Black and Latino individuals contract and die from COVID-19 more than non-Hispanic White people relative to their share of the U.S. population.[12]

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maternal-infant-death-rates/ ("Numerous studies show that after controlling for education and socioeconomic status, African American women remain at higher risk for maternal and infant mortality.").

[9] A. Baciu et al. eds., *The Root Causes of Health Inequity*, Communities in Action: Pathways to Health Eq., ch. 3 (2017), https://www.ncbi.nlm.nih.gov/books/NBK425845/.

[10] Kevin Fiscella & David R. Williams, *Health Disparities Based on Socioeconomic Inequities: Implications for Urban Health Care*, 79 Acad. Med., No. 12, p. 1139 (Dec. 2004), https://scholar.harvard.edu/files/davidrwilliams/files/2004-health_disparities_based-williams.pdf.

[11] Santa Clara Cty. Pub. Health, *Health and Social Inequity in Santa Clara County*, Santa Clara Cty., p. 7 (Jan. 2011), https://publichealth.sccgov.org/sites/g/files/exjcpb916/files/ship-exec-summary.pdf.

[12] *Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC*, Ctrs. for Disease Control & Prevention (last accessed Sept. 20, 2021), https://covid.cdc.gov/covid-data-tracker/#demographics; *Disparities in Deaths from COVID-19: Racial and Ethnic Health Disparities*, Ctrs. for Disease Control & Prevention (last updated Dec. 10, 2020), https://www.cdc.gov/

In the District of Columbia, for example, Black residents account for 71% of coronavirus-related deaths despite representing only 37% of the population.[13] Local governments recognize and struggle with these disparities when they take steps to combat COVID-19.[14] As one researcher explained, "[p]ublic policies have the power to enhance health and also exacerbate health disparities. Health interventions that are adapted for local contexts and community characteristics are more effective than standard approaches."[15]

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coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/disparities-deaths.html.

[13] *COVID-19 Deaths by Race/Ethnicity*, Kaiser Fam. Found. (last updated Sept. 8, 2021), https://www.kff.org/other/state-indicator/covid-19-deaths-by-race-ethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. The higher risks are a result of many factors, including that people from racial minority groups (i) are more likely to work in essential front-line settings, (ii) have less flexibility to work from home or leave jobs that expose them to the virus, (iii) face barriers to accessing health care, (iv) live in more crowded conditions, (v) are more likely to ride public transportation, and (vi) suffer from higher rates of obesity, high blood pressure, and other conditions that increase the risk of severe illness from COVID-19.

[14] The City of Boston, for example, developed a COVID-19 Health Inequities Task Force to examine disparities in access to testing and treatment. *COVID-19 Health Inequities Task Force Created*¸ City of Boston (Oct. 16, 2020), https://www.boston.gov/news/covid-19-health-inequities-task-force-created.

[15] Monica Webb Hooper et al., *COVID-19 and Racial/Ethnic Disparities*, JAMA Network (May 11, 2020), https://jamanetwork.com/journals/jama/fullarticle/2766098.

Racial and economic health disparities are particularly acute in the context of reproductive health care, which includes, *inter alia*, prenatal and postnatal care, contraceptive use and access, family planning, testing and treatment for sexually transmitted infections, and access to obstetrics and gynecological services, including abortion.[16] Yet, "*in almost every aspect of reproductive health*, women of color have poorer health outcomes than white women."[17] Socioeconomic status also correlates to reproductive health outcomes: "[a] mother's low socioeconomic status is associated with multiple risk factors for adverse birth outcomes."[18] For example:

> ***Contraceptives***. "Cost is a known barrier to contraceptive access and use for some women," particularly with respect to long-acting and the most easily maintainable contraceptive devices.[19]

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[16] *Reproductive Health*, Ctrs. for Disease Control & Prevention (last updated Aug. 31, 2021), https://www.cdc.gov/reproductivehealth/index.html; *Reproductive Health Strategy*, World Health Org., p. 21 (2004), https://apps.who.int/iris/bitstream/handle/10665/68754/WHO_RHR_04.8.pdf.

[17] Jamila Taylor, *Women of Color Will Lose the Most if* Roe v. Wade *Is Overturned*, Ctr. Am. Progress (Aug. 23, 2018), https://www.americanprogress.org/issues/women/news/2018/08/23/455025/women-color-will-lose-roe-v-wade-overturned/ (emphasis added); Samantha Artiga et al., *Racial Disparities in Maternal and Infant Health: An Overview*, Kaiser Fam. Found. (Nov. 10, 2020), https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief.

[18] Fiscella & Williams, *supra* note 10, at 1140.

[19] Madeline Y. Sutton et al., *Racial and Ethnic Disparities in Reproductive Health Services and Outcomes*, 137 J. Obstetrics &

Fewer Black and Hispanic women use contraceptives than White women.[20]

Preterm Births. Births before 37 weeks of gestation are the leading cause of death in infants.[21] In the United States, low socioeconomic status is a risk factor for preterm birth.[22] According to data collected by King County, Washington, women living in high-poverty areas have 33% more preterm births than women in low-poverty areas. Nationwide, Black women are twice as likely as White women to have preterm births.[23] Similarly,

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Gynecology, No. 2 (Feb. 2021), https://journals.lww.com/greenjournal/Fulltext/2021/02000/Racial_and_Ethnic_Disparities_in_Reproductive.5.aspx.

[20] *Id*. ("Awareness of historical and modern-day racial injustices often contribute to the lower rate of contraceptive use among Black and Hispanic women; there is a distrust by some patients that has yet to be acknowledged by many clinicians.").

[21] Jasmine Johnson et al., *Racial Disparities in Prematurity Persist Among Women of High Socioeconomic Status (SES)*, 222 Am. J. Obstetrics & Gynecology, No. 1, Supp. (Jan. 1, 2020), https://www.ajog.org/article/S0002-9378(19)31430-9/fulltext; *Premature Births in Mississippi*, Miss. State Dep't of Health (May 24, 2021), https://msdh.ms.gov/msdhsite/_static/44,0,381,658.html ("Premature births are a major public health challenge in Mississippi.").

[22] *Preterm Labor and Premature Birth: Are You at Risk?*, March of Dimes (Mar. 2018), https://www.marchofdimes.org/complications/preterm-labor-and-premature-birth-are-you-at-risk.aspx.

[23] Tracy A. Manuck, *Racial and Ethnic Differences in Preterm Birth: A Complex, Multifactorial Problem*, 41 Seminars in Perinatology, No. 8 (Sept. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6381592/.

from 2017-2019, Miami-Dade County, Florida recorded a preterm birth rate of 7.2% for White women and 14.1% for Black women.[24]

Prenatal Care. Women who do not receive proper prenatal care are at higher risk for adverse pregnancy outcomes.[25] Nationwide, Black and Hispanic women are less likely than White women to receive prenatal care during their first trimester.[26] In King County, 8.3% of Black women and 6.0% of Hispanic women do not receive adequate prenatal care, compared to only 3.5% of White women.

Infant Mortality. Nationwide, Black mothers experience twice the infant mortality rate (11.11 infant deaths per 1,000 live births)[27] as the national average (5.8).[28] Similarly, "[f]etal deaths

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[24] *Preterm by Race/Ethnicity: Miami-Dade County, 2017-2019 Average*, March of Dimes (2021) (last accessed Sept. 19, 2021), https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=12086&top=3&stop=63&lev=1&slev=6&obj=1.

[25] Cristina Novoa, *Ensuring Healthy Births Through Prenatal Support*, Ctr. Am. Progress (Jan. 31, 2020), https://www.americanprogress.org/issues/early-childhood/reports/2020/01/31/479930/ensuring-healthy-births-prenatal-support/.

[26] J.A. Martin et al., *Births: Final Data for 2019*, 70 Nat'l Vital Stat. Reps., No. 2, pp. 6, 31 (Mar. 23, 2021), https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf.

[27] Baciu et al., *supra* note 8.

[28] Sofia Carratala & Connor Maxwell, *Health Disparities by Race and Ethnicity*, Ctr. Am. Progress (May 7, 2020), https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/.

are 2 times more likely among Pittsburgh's Black women compared to White women."[29] In some areas, the disparity is even greater: in Ramsey County, Minnesota, Black babies suffer an infant mortality rate of 12.4, as compared to 4.4 for White babies.[30] The infant mortality disparity also holds true based on socioeconomic status.[31]

Maternal Mortality. Nationally, "Black women are dying at three to four times the rate of white women due to pregnancy-related issues,"[32] a disparity that has been directly linked to racism-based delays in care.[33] "Hispanic women in New York City are three times more likely than non-Hispanic white women to suffer pregnancy-related mortality."[34] Additionally, between 2003 and 2007, women from counties with high poverty rates were

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[29] Junia Howell et al., *Pittsburgh's Inequality Across Gender and Race*, City of Pittsburgh's Gender Equal. Comm'n, p. 14 (2019), https://www.socialwork.pitt.edu/sites/default/files/pittsburghs_inequality_across_gender_and_race_07_19_20_compressed.pdf.

[30] *Health Equity Data Analysis Final Report*, Saint Paul-Ramsey Cty. Pub. Health, p. 9 (2017), https://www.ramseycounty.us/sites/default/files/Departments/Public%20Health/HEDA_10.12.17.pdf.

[31] Fiscella & Williams, *supra* note 10, at 1140.

[32] Taylor, *supra* note 17; Sutton, *supra* note 19.

[33] Sutton, *supra* note 19 ("When individual recent cases were reviewed, clinician-level biases and racism often contributed to delayed or absent care that led to deaths.").

[34] Elizabeth A. Howell et al., *Severe Maternal Morbidity Among Hispanic Women in New York City: Investigation of Health Disparities*, 129 Obstetrics & Gynecology, No. 2 (Feb. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5380443/.

120% more likely to suffer maternal mortality than were women in low-poverty counties.[35]

Reproductive health care cannot be divorced from questions of race and socioeconomic status. Decisions regarding reproductive care must be made with an understanding and acceptance of how those decisions will affect efforts already struggling to achieve reproductive health equity.

B. Local Governments Have Made Extensive Commitments to Address Health Disparities

Local governments recognize the crucial role they play in eliminating racial and economic health disparities.[36] Local health departments "are at the vanguard in the fight to eliminate disparities in the population, and they are strategically positioned to address this issue as they represent the frontline of public health."[37] Because localities have intimate

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[35] Gopal K. Singh, *Maternal Mortality in the United States, 1935-2007*, Dep't Health & Hum. Servs., p. 3 (2010), https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf.

[36] The National Association of County and City Health Officials recognizes over 2,800 local health departments that are often the only entities providing key health services. *2019 National Profile of Local Health Departments*, Nat'l Ass'n Cty. & City Health Offs., p. 21 (2019), https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf.

[37] Gulzar H. Shah & John P. Sheahan, *Local Health Departments' Activities to Address Health Disparities and Inequities: Are We Moving in the Right Direction?*, 13 Int'l J. Env't Rsch. & Pub. Health, No. 1 (2016), https://www.mdpi.com/1660-4601/13/1/44/htm#B30-ijerph-13-00044 (stating that local health

knowledge of their communities, and as a result of partnerships with trusted community-based organizations, "they are in a better position than other types of health agencies to eliminate disparities specific to their jurisdictions" and populations by structuring more tailored programs.[38] Their efforts have included a particular focus on reproductive health. For example, Columbus, Ohio Public Health runs a Women's Health and Wellness Center, which provides confidential reproductive health care, exams, and contraceptive services.[39]

In order to address disparities in reproductive health, localities have implemented programs focused on low-income women and women of color. Clark County, Nevada, for example, has developed an action plan to increase community engagement in reproductive services, focusing in part on increasing access for low-income and underinsured residents.[40] Los Angeles County recently enacted the African

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departments serve their populations "by working with strategic partners in reducing the inequities leading to disparities or assuring access to health care or by directly providing primary care on a limited scale, particularly to underserved and disenfranchised population subgroups").

[38] *Id.*

[39] Columbus Pub. Health, *Women's Health and Wellness Center*, City of Columbus (2021), https://www.columbus.gov/publichealth/programs/Women-s-Health,-Family-Planning/.

[40] *Community Engagement in Reproductive Health Services: Clark County*, Nevada Community Action Plan, pp. 13-15 (Dec. 2019), https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/Community%20Action%20Plan%20%20%202%204%202020%20(002).pdf.

American Infant and Maternal Mortality Initiative, which provides a wide range of services to reduce mortality rates among Black women and their infants.[41] In 2009, the Baltimore City Health Department worked with local health providers, community partners, public agencies, private donors, and academics to develop a locally driven initiative to reduce instances of premature birth, low birth weight, and unsafe sleep; since the initiative's launch, "the disparity between white and black infant deaths decreased by almost 40%."[42]

Localities engage in health-related conversations with their communities by partnering with community organizations[43] and seeking community input.[44] The City of Cincinnati, for example, partners with multiple organizations to engage with the community and provide care, including reproductive health care. Many of these community partnerships

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[41] Los Angeles Cty. Dep't Pub. Health, *About the Initiative*, The Los Angeles Cty. African Am. Infant & Maternal Mortality Initiative (2019), https://www.blackinfantsandfamilies.org/about.

[42] *B'more for Healthy Babies*, Baltimore City Health Dep't, https://health.baltimorecity.gov/maternal-and-child-health/bmore-healthy-babies.

[43] Baciu et al., *supra* note 8 ("The health care system has an important role to play in addressing the social determinants of health. At the community level, it can partner with community-based organizations and explore locally based interventions . . . .").

[44] Sarah Newman et al., *2015 Local Board of Health National Profile*, Nat'l Ass'n Cty. & City Health Offs., p. 3 (June 2016), https://www.naccho.org/uploads/downloadable-resources/Local-Board-of-Health-Profile.pdf.

focus on outreach to underserved communities. King County, for example, runs a Prenatal Care Coordination program that partners with a community-based doulas-of-color collective to deliver culturally aligned prenatal services. San Mateo County, California operates a Black Infant Health program that partners with OB/GYN health care partners and community organizations to reach Black women and provide health care in a trusted way.

These and other community partnerships are pivotal elements in creating sustained structural interventions that can reduce health disparities.[45] Community partnerships are also significant generators of trust.[46] Whether addressing COVID-19 or confronting endemic disparities in reproductive health, interventions that are adapted for local contexts and community characteristics are more effective than undifferentiated approaches.[47]

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[45] Arleen F. Brown et al., *Structural Interventions to Reduce and Eliminate Health Disparities*, 109 Am. J. Pub. Health, Supp. 1, p. S73 (2019), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2018.304844.

[46] Irene Dankwa-Mullan et al., *The Science of Eliminating Health Disparities: Summary and Analysis of the NIH Summit Recommendations*, Am. J. Pub. Health (Apr. 2010), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2010.191619 ("Community members bring an essential understanding, expertise, and trust to the realm of research.").

[47] Hooper, *supra* note 15.

II. ABORTION BANS SIGNIFICANTLY WORSEN EXISTING DISPARITIES IN HEALTH OUTCOMES

Women of color and women with less financial means will be disproportionately affected if this Court allows the Mississippi Ban, or even more restrictive bans, to go into effect. Denial of access to abortion causes negative health and economic consequences, further heightening already pervasive disparities. Any infringement of the right to abortion, a right on which *Amici* have relied to address the needs of all segments of their populations, negatively impacts continued efforts to combat health disparities.

A. Pre-Viability Abortion Bans Disproportionately Affect Pregnant Women of Color and Lower-Income Pregnant Women

If the Mississippi Ban—or any pre-viability gestational ban—goes into effect, women of color and lower-income women would disproportionately lose access to abortion services because these groups are more likely to have abortions later than White women and women with higher socioeconomic status. On average, Black women have abortions significantly later than White women.[48] And lower-income women

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[48] Alexa L. Solazzo, *Different and Not Equal: The Uneven Association of Race, Poverty, and Abortion Laws on Abortion Timing*, 66 Soc. Probs., p. 523 (Aug. 28, 2018); Rachel K. Jones & Lawrence B. Finer, *Who Has Second-Trimester Abortions in the United States?*, 85 Contraception, No. 6, p. 551 (June 2012) ("Black women were more likely than white women to [obtain] a second-trimester abortion by a factor of 1.50."); Ted Joyce &

are more likely to have abortions later than women above 200% of the federal poverty level.[49] The results of these studies and analyses reflect *Amici*'s experience.

Delay in accessing abortion typically results from difficulties related to scheduling, cost, and distance. Women most commonly cite the time needed to make arrangements as the reason for delay, with more low-income women referencing this need.[50] Relatedly, the most common obstacle women note as delaying their ability to obtain an earlier abortion is the need to raise money to pay for it.[51] Because Black and Hispanic

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Robert Kaestner, *The Impact of Mississippi's Mandatory Delay Law on the Timing of Abortion*, 32 Persps. on Sexual & Reprod. Health, No. 1 (Jan./Feb. 2001), https://www.guttmacher.org/journals/psrh/2001/01/impact-mississippis-mandatory-delay-law-timing-abortion (study finding that in Mississippi, nonwhite women are more likely to delay getting abortion).

[49] Eleanor A. Drey et al., *Risk Factors Associated with Presenting for Abortion in the Second Trimester*, 107 Obstetrics & Gynecology, p. 134 (Jan. 2006) (study finding that "[t]rouble with Medi-Cal," such as difficulty finding a provider, "was associated with a 4-fold increased risk of second-trimester abortion"); Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception, No. 4 (Oct. 2006); Solazzo, *supra* note 48, at 532 ("[P]oorer women are more likely to delay having an abortion than wealthier women.").

[50] Finer, *supra* note 49.

[51] *Id.*; Jessica W. Kiley et al., *Delays in Request for Pregnancy Termination: Comparison of Patients in the First and Second Trimesters*, 81 Contraception, No. 5 (May 2010) ("Multivariate analyses indicate that most significant obstacles associated with request for abortion with late gestational age were (1) difficulties

women experience poverty at more than double the rate of their White counterparts, a larger proportion of Black and Hispanic women experience economic barriers to earlier abortions than do White women.[52]

Distance, which also plays a key role in the timing of abortions, disproportionately affects women of color. Abortion clinics tend to be located farther away from Black and Hispanic communities; six out of ten abortion providers are located in communities where more than half the residents are White.[53] Traveling as few as 25 miles for an abortion is associated with later abortions among Black and Hispanic women.[54]

The Mississippi Ban would cause women of color and low-income women to lose access to abortion services in a way that White, higher-income women would not.

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financing the abortion and (2) needing to travel long distances to the clinic.").

[52] Solazzo, *supra* note 48, at 523; Marshall H. Medoff, *Race, Restrictive State Abortion Laws and Abortion Demand*, 41 Rev. Black Polit. Econ. (Mar. 25, 2014) ("Medicaid funding restrictions [of abortions] have a greater impact on black and Hispanic women who are relatively more likely to be on Medicaid than white women.").

[53] Guttmacher Advisory, *Claim That Most Abortion Clinics Are Located in Black or Hispanic Neighborhoods Is False*, Guttmacher Inst. (June 2014), https://www.guttmacher.org/claim-most-abortion-clinics-are-located-black-or-hispanic-neighborhoods-false.

[54] Solazzo, *supra* note 48, at 533, 535.

B. Pregnant Women Who Cannot Access Abortion Care Face Increased Health Risks and Economic Vulnerability, Which Exacerbates Existing Health Disparities

Pregnant women who are denied access to abortion face serious health and economic consequences. Those consequences are more pronounced for women of color and for women of lower socioeconomic status—the very population of women most likely to be denied abortion as a result of pre-viability bans. Moreover, the negative health and economic impacts of abortion denial can create a vicious cycle, intensifying disparities.

Restrictions on abortion have pronounced health consequences. As this Court has recognized, childbirth is more dangerous than abortion. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016).[55]

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[55] Numerous studies have shown that abortion is one of the safest outpatient medical procedures performed in the United States. *See, e.g.*, Ushma D. Upadhyay et al., *Abortion-Related Emergency Department Visits in the United States: An Analysis of a National Emergency Department Sample*, BMC Med. J., Art. No. 88, p. 8 (2018), https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-018-1072-0.pdf ("The major incident rate for abortion (0.1%) is lower than the published rates for pregnancy (1.4%), as well as other common procedures such as colonoscopy (0.2%), wisdom tooth removal (1.0%), and tonsillectomy (1.4%)."). Mortality from childbirth is fourteen times higher than from abortion. Caitlin Gerdts et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 Women's Health Issues, p. 55 (Nov. 2015), https://www.whijournal.com/article/S1049-3867(15)00158-9/pdf.

Indeed, as described above, the health risks of carrying a pregnancy to term are greater for women of color and women of lower socioeconomic status (*i.e.*, the women most likely to be denied abortions).

In addition to the risk of negative *health* consequences, pregnant women who are denied access to abortion care are substantially more likely to face *economic* hardships. A study comparing women who obtained abortions with those who were denied abortions found that the families of those who were denied were four times more likely to be living below the federal poverty line.[56] These women also had 78% more past due debt and 81% more negative public records, such as bankruptcies and evictions, than women who were not denied abortions.[57] These findings are consistent with other studies demonstrating the financial challenges that can be associated with having a young child, which are particularly severe for parents of color due to discrimination and underlying disparities.[58]

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[56] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health, No. 3, pp. 410-13 (2018), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304247.

[57] Sarah Miller et al., *The Economic Consequences of Being Denied an Abortion*, Nat'l Bureau of Econ. Rsch., p. 3 (Jan. 2020), https://www.nber.org/system/files/working_papers/w26662/w26662.pdf.

[58] Amy Traub et al., *The Parent Trap: The Economic Insecurity of Families with Young Children*, Demos, pp. 8, 12, 14-15 (2016), https://www.demos.org/sites/default/files/publications/Parent%20Trap.pdf (explaining that for parents of color the economic hardships associated with having a young child are layered on

These economic hardships and health risks can exacerbate each other, with the economic stress caused by abortion restrictions undercutting health and vice versa. People who cannot afford adequate shelter or food struggle to pay for preventative health care.[59] In states that have not expanded Medicaid, people with lower incomes sometimes cannot access health care coverage, leaving them unable to afford health care. Meanwhile, pregnant women are routinely denied workplace accommodations related to health, denials that can cost them their jobs.[60] Taken

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racial disparities in pay and workplace flexibility, making overall economic impact of having a young child more severe); *id*. at 1 (showing that having child under age of five results in 14% to 36% drop in income relative to households without child). Notably, states with restrictive abortion policies are less likely to adopt policies that are supportive of women's and children's well-being, such as expanding Medicaid coverage, creating employment protections for parents and pregnant workers, and providing childcare assistance. *See Evaluating Priorities: Measuring Women's and Children's Health and Well-being Against Abortion Restrictions in the States*, Ibis Reprod. Health & Ctr. for Reprod. Rts. (2017), https://www.reproductiverights.org/sites/default/files/documents/USPA-Ibis-Evaluating-Priorities-v2.pdf.

[59] Usha Ranji et al., *Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities*, Kaiser Fam. Found. (Nov. 14, 2019), https://www.kff.org/womens-health-policy/report/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities/.

[60] Carly McCann & Donald Tomaskovic-Devey, *Pregnancy Discrimination at Work,* Ctr. for Emp. Eq., pp. 8-9 (May 26, 2021), https://www.umass.edu/employmentequity/sites/default/files/Pregnancy%20Discrimination%20at%20Work.pdf ("Based on these survey results, an estimated 250,000 women are denied accommodations related to their pregnancies each year. This is

together, denying women access to abortion can create a cycle of health problems and financial struggle that extends far beyond pregnancy.

The physical and economic toll of abortion bans is not limited to pregnant women, but ripples out to their families and their broader communities. Children born as a result of their mother being denied an abortion are more likely to grow up in a household without enough money to pay for basic living expenses than are children born to women within five years after the woman had an abortion.[61] Additionally, the stress of navigating restrictive abortion laws may itself worsen the health of the pregnant woman and in turn the later health of her child.[62] Further, nearly 60% of people who obtain abortions already have at

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likely a conservative estimate of unmet need . . . ."); *Young v. United Parcel Serv.*, 575 U.S. 206 (2015) (finding violation of Pregnancy Discrimination Act when UPS refused to give pregnant driver a doctor-recommended accommodation and then placed her on unpaid leave).

[61] 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 J. Am. Med. Ass'n Pediatrics (2018), https://jamanetwork.com/journals/jamapediatrics/fullarticle/2698454.

[62] Anusha Ravi, *Limiting Abortion Access Contributes to Poor Maternal Health Outcomes*, Ctr. Am. Progress (June 13, 2018), https://www.americanprogress.org/issues/women/reports/2018/06/13/451891/limiting-abortion-access-contributes-poor-maternal-health-outcomes/.

least one child.[63] Relative to the children of women who obtain an abortion, the children of women who are denied abortions have lower child development scores and are more likely to live in poverty.[64] Like the harms abortion denial imposes on pregnant women, these harms disproportionately affect children of color.[65]

Given the connection between abortion access and physical and socioeconomic well-being, achieving *Amici*'s goal of eliminating health disparities is impossible without continued access to legal abortion—access on which many localities have depended since *Roe* was decided.[66]

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[63] *Induced Abortion in the United States*, Guttmacher Inst. (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

[64] Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics (Feb. 1, 2019), https://www.jpeds.com/article/S0022-3476(18)31297-6/fulltext.

[65] Maria Trent et al., *The Impact of Racism on Child and Adolescent Health*, 144 Pediatrics, No. 2 (Aug. 2019), https://pediatrics.aappublications.org/content/pediatrics/144/2/e20191765.full.pdf (explaining that "[r]acism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families"); Neil Bhutta et al., *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances*, FEDS Notes (Sept. 28, 2020), https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm ("[T]he typical White family has eight times the wealth of the typical Black family and five times the wealth of the typical Hispanic family.").

[66] *Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention*,

C. Pre-Viability Abortion Bans Would Erode the Community Trust That Is Fundamental to Local Efforts to Care for Their Residents and Reduce Health Disparities

Amici rely on the trust of the communities they serve to promote health and well-being and to eradicate health disparities. Pre-viability abortion bans undermine that trust by driving a wedge between providers and patients and by preventing medical professionals and public health officials from offering access to the full spectrum of reproductive health care. Because underserved communities already experience higher rates of medical mistrust,[67] pre-viability abortion bans reinforce mistrust of health care providers and stymy efforts by local governments like *Amici* to reduce disparities in health care.

Pre-viability abortion bans fundamentally interfere with the provider-patient relationship by preventing patients from receiving medically

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Am. Pub. Health Ass'n (Nov. 3, 2015), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights ("A public health strategy to achieve health in all policies, economic equality, social justice, and human rights should protect and advance women's access to abortions and reproductive justice.").

[67] Katrina Armstrong et al., *Racial/Ethnic Differences in Physician Distrust in the United* States, 97 Am. J. Pub. Health, No. 7 (July 2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1913079/ (being Black, Hispanic, and of lower socioeconomic status are all associated with higher distrust of physicians).

appropriate care. These bans erode pregnant women's trust in the medical system because the care they seek either is not available or is difficult to access. Both providers and patients report damage to the provider-patient relationship in connection with restrictions on abortion, including limiting what information providers may share about abortion, mandating that providers share inaccurate information, and preventing providers from offering abortion care altogether. For example, in 2019, the U.S. Department of Health and Human Services released a rule that prevented Title X-funded recipients—which primarily serve low-income patients—from "perform[ing], promot[ing], or support[ing] abortion as a method of family planning."[68] As a result, an estimated 25% of Title X providers dropped out of the network, reducing capacity by at least 46%.[69] Individual providers reported worrying about being able to speak freely with patients, and major medical groups argued that the rule would force doctors to violate their ethical obligation to provide honest and informed advice.[70]

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[68] 42 CFR § 59.14 (2019), https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-59.

[69] Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half*, Guttmacher Inst. (Apr. 15, 2021), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half.

[70] Mara Gordon, *Doctors Say Federal Rules on Discussing Abortion Inhibit Relationships With Patients*, NPR (Sept. 9, 2019), https://www.npr.org/sections/health-shots/2019/09/09/756103421/doctors-say-federal-rules-on-discussing-abortions-inhibit-relationships-with-pat; Andis Robeznieks, *New Federal Regulations Impose Gag Rule On Physicians, Restrict Access To*

Like the Title X "gag rule," abortion bans chill provider speech by penalizing open and honest conversations about the full spectrum of reproductive health care. The recent six-week abortion ban in Texas, for example, has created an "ethical quandary" for providers, who must balance their obligation to give candid medical counsel against their fear of being targeted for "aiding and abetting" abortion.[71]

Moreover, even if pregnant women are not the subject of abortion bans, apprehension of prosecution undermines the doctor-patient relationship and the trust on which it is predicated. Studies demonstrate, for example, that when doctors are required by law to report suspected drug use by pregnant women to law enforcement, pregnant women report not "trust[ing] health care providers to protect them" and "avoid[ing]" or disengaging from prenatal care.[72] Although existing bans primarily target abortion providers (rather than pregnant women), allowing even the misperceived

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Critical Services, Am. Med. Ass'n (Feb. 22, 2019), https://www.ama-assn.org/delivering-care/physician-patient-relationship/new-federal-regulations-impose-gag-rule-physicians.

[71] Lydia Wheeler, *Texas Abortion Law Creates Ethical Quandary for Doctors*, Bloomberg L. (Sept. 10, 2021), https://news.bloomberglaw.com/pharma-and-life-sciences/texas-abortion-law-creates-ethical-quandary-for-doctors.

[72] Comm. on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist*, Am. Coll. Obstetricians & Gynecologists, Comm. Op. No. 473 (Jan. 2011) (reaffirmed 2014), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/01/substance-abuse-reporting-and-pregnancy-the-role-of-the-obstetrician-gynecologist.

threat of criminal prosecution to come between providers and patients leads to confusion and fear by pregnant women, including those who seek care. In states that significantly restrict abortion, providers have reported that patients fear prosecution for seeking care—even where those restrictions do not provide for any criminal prosecution, let alone prosecution of pregnant women.[73]

As previous intrusions into relationships between reproductive health care providers and their patients demonstrate, pre-viability bans on abortion will directly threaten *Amici*'s ability to further their residents' health and to enact programs that rely on trust in the medical community.

III. A DECISION UPHOLDING MISSISSIPPI'S BAN COULD TRIGGER ABORTION BANS IN MORE THAN TWENTY STATES, LEADING TO CHAOS AND CONFUSION

Petitioners maintain that overruling *Roe* would simplify the prevailing abortion jurisprudence by undoing an "unworkable" standard and replacing it

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[73] For example, one patient confided in an abortion provider that she feared receiving the death penalty after a bill that would allow capital punishment for abortion was debated in the Texas legislature. *Texas OB/GYN: My Existence Is In Violation Of The New Abortion Law*, NPR (Aug. 29, 2021), https://www.npr.org/2021/08/29/1032259863/texas-ob-gyn-my-existence-is-in-violation-of-the-new-abortion-law. Confusion about the legality of abortion is common as restrictions proliferate. *See infra* note 84.

with rational basis review. That is not correct.[74] Instead, potentially within hours of an opinion by this Court that even theoretically compromises *Roe*, legal uncertainty will ensue as providers, patients, and *Amici* try to determine which laws apply to abortion access in their states. As the dust settles, women of means will—as they always have—travel and leverage relationships with private physicians to access abortion care, while many women of color and women with lower incomes are left behind.

Although the Mississippi Ban restricts abortions after fifteen weeks, a reversal of the decision below could lead to the immediate imposition of abortion bans well *before* fifteen weeks, and thus even further before viability, in more than twenty states. Those bans come in the form of (i) post-*Roe* abortion bans that are currently enjoined, (ii) pre-*Roe* laws that have never been repealed, and (iii) so-called "trigger bans."

A. More Than Twenty States—Including Mississippi—Have Extreme Abortion Bans Poised to Go into Effect if *Roe* Is Overturned

The implications of upholding the Mississippi Ban extend well beyond the state of Mississippi and a fifteen-week cut-off for abortion access. At least twenty-one states, including Mississippi, already have

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[74] Richard H. Fallon, Jr., *If* Roe *Were Overruled: Abortion and the Constitution in a Post-*Roe *World*, 51 St. Louis L.J. 611, 648 (2007) ("The notion that by overruling *Roe* the Supreme Court could extract itself from controversial assessments of the constitutionality of state anti-abortion legislation is not just a fallacy. It is a delusion.").

other laws on the books that could be used to severely restrict or eliminate abortion access.[75]

Although the Mississippi Ban prohibits abortion after fifteen weeks, Mississippi is one of at least nine states with even more severe abortion bans that were passed after *Roe* but that are currently enjoined on the basis of *Roe*. Those bans could go into effect if the constitutional right to abortion were overruled.[76] Seven of the nine states passed restrictive abortion bans based on gestation in the first half of 2019 alone—Missouri at eight weeks; Georgia, Kentucky, Louisiana, Mississippi, and Ohio at six weeks; and Alabama would restrict abortion altogether.[77] The injunctions of these bans were all expressly based on

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[75] *Abortion Policy in the Absence of* Roe, Guttmacher Inst. (as of August 1, 2021), https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe; *What if* Roe *Fell?*, Ctr. for Reprod. Rts. (last accessed Sept. 20, 2021), https://maps.reproductiverights.org/what-if-roe-fell#not-protected.
Mississippi itself has a pre-*Roe* ban on abortions at any gestational age, a post-*Roe* six-week ban, and a "trigger law" intended to ban virtually all abortion upon a determination by the State Attorney General that the Supreme Court has overturned *Roe v. Wade*. Miss. Code Ann. § 97-3-3(1)(a)-(b); *id.* § 41-41-34.1; *id.* § 41-41-45.

[76] *Abortion Policy*, *supra* note 75 (listing Alabama, Arkansas, Georgia, Kentucky, Mississippi, Missouri, Ohio, South Carolina, and Tennessee as states with "post-*Roe* restrictions that could take effect if *Roe* [is] overturned").

[77] K.K. Rebecca Lai, *Abortion Bans: 9 States Have Passed Bills to Limit the Procedure This Year*, N.Y. Times (last updated May 29, 2019), https://www.nytimes.com/interactive/2019/us/abortion-laws-states.html. Arkansas and Iowa also have post-*Roe* bans. *See* Ark. Code Ann. §§ 5-61-301-304; S.F. 359, 87th Gen. Assemb. (Iowa 2018).

a fundamental right to abortion as recognized by Supreme Court precedent.[78]

Seven states (Alabama, Arizona, Arkansas, Michigan, Mississippi, West Virginia, and Wisconsin) retain abortion bans that pre-date *Roe v. Wade* and that could go into effect if the Mississippi Ban is upheld. These pre-*Roe* statutes carry harsh criminal penalties for violation and ban abortion without regard to viability or gestational age, with extremely limited exceptions.[79]

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[78] *SisterSong Women of Color Reprod. Just. Collective v. Kemp*, 472 F. Supp. 3d 1297, 1302 (N.D. Ga. 2020) (striking down Georgia's abortion ban because "[t]he hallmark of the Supreme Court's abortion jurisprudence is *Roe v. Wade*[,] wherein the Court held that the Due Process Clause of the Fourteenth Amendment provides a fundamental constitutional right of access to abortions"). In Ohio, there could be an attempt to revive a "heartbeat bill" banning abortion at six weeks—a point at which most women do not even know they are pregnant—if an injunction premised on *Roe*'s fundamental right is lifted. Ohio S.B. 23, 123rd Gen. Assemb. (2019); *Pre-Term Cleveland v. Yost*, 394 F. Supp. 3d 796, 800 (S.D. Ohio 2019) (concluding that Ohio's abortion ban is unconstitutional because "[t]he law is well-settled that women possess a fundamental constitutional right of access to abortions") (citing *Roe v. Wade*).

[79] *See, e.g.*, Wis. Stats. Ann. 940.04(2), which provides that any person, other than the pregnant woman, who "[i]ntentionally destroys the life of an unborn quick child" is guilty of a Class E Felony, which carries penalties of up to 15 years in prison and $50,000 in fines. Wisconsin's pre-*Roe* statute allows abortion only if necessary to save the life of the mother. Wis. Stats. Ann. 940.04(5)(b). Mississippi's statute allows abortions only where necessary "for preservation of the mother's life" or where pregnancy was caused by rape. Miss. Code Ann. § 97-3-3(1)(a)-(b).

In addition to these restrictions, twelve states (Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, Oklahoma, Tennessee, Texas, South Dakota, and Utah) have so-called "trigger laws" or "trigger bans," the purpose of which is to totally ban abortion in the event that *Roe v. Wade* is overruled or modified.[80] All of these laws purport to enact a *total* ban if the Court no longer recognizes a fundamental right to abortion. Although the constitutionality of the mechanism of these laws is questionable as well,[81] any decision that upholds the Mississippi Ban will likely be perceived by some as triggering these laws, leading to constitutional confusion and a wave of litigation about how to interpret the new post-*Roe* standard for abortion. This chaos will only interfere with *Amici*'s efforts to address their communities' needs.[82]

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[80] *Abortion Policy*, *supra* note 75. Two additional trigger bans—in Texas and Oklahoma—were passed in 2021. Tex. H.B. 1280; Okla. S.B. 918 § 18.

[81] Heidi S. Alexander, *The Theoretic and Democratic Implications of Anti-Abortion Trigger Laws*, 61 Rutgers L. Rev. 381 (2009) (arguing that trigger laws are unconstitutional legislative entrenchment); Matt Berns, *Trigger Laws*, 97 Geo. L.J. 1639, 1688 (2009) (arguing that trigger laws will inevitably lead to "conflicting constitutional interpretations from the courts and high-ranking non-judicial officers [and] leave lower-ranking officials with poor guidance as to what the Constitution requires and result in those officials' inconsistent enforcement of constitutional norms").

[82] State restrictions permitted as a result of a decision upholding the Mississippi Ban would further interfere with local public health authority by preempting efforts by localities to support access to abortion. For example, Texas's trigger law would undercut Austin's 2019 decision to devote $150,000 to support

Previous state abortion bans are instructive regarding the confusion that will ensue. For example, after Ohio's "heartbeat bill" was passed, nearly 40% of the women studied thought that abortion was *totally* illegal (or were unsure) in the state.[83] After Alabama passed a total abortion ban, Alabama abortion providers described a deluge of calls from women desperately seeking information about whether abortion was illegal in their state, despite the fact that the Alabama law never went into effect.[84] Similar

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abortion access services, as well as Travis County's 2013 resolution urging the state to "reaffirm the fundamental right of women to make decisions about their health care," including the decision to get an abortion. Kristin Lam, *Texas Capital of Austin Approves First-in-the-Nation Funding for Abortion Transportation, Lodging, Childcare*, USA Today (Sept. 12, 2019), https://www.usatoday.com/story/news/nation/2019/09/12/austin-abortion-funding-access-services-texas-lawsuit-first-city/2306192001/; *A Resolution to Support Women's Healthcare*, Travis Cty. Comm'r Ct. (Jan. 22, 2013), https://www.nirhealth.org/wp-content/uploads/2015/07/Jan2013-Texas-PP-resolution.pdf. Local governments find it far more difficult to meet the public health needs of their communities when states preempt their efforts, as has happened with state decisions preempting local responses to the COVID-19 pandemic or provision of paid sick leave. *See, e.g.*, H. Elizabeth Peters et al., *State Preemption of Local Paid Sick Days Ordinances*, Urban Inst. (Oct. 29, 2020), https://www.urban.org/research/publication/state-preemption-local-paid-sick-days-ordinances.

[83] Maria F. Gallo et al., *Passage of Abortion Ban and Women's Accurate Understanding of Abortion Legality*, 63 Am. J. Obstetrics & Gynecology, p. 63 (July 2021), https://www.sciencedirect.com/science/article/pii/S000293782100096X.

[84] Kim Chandler & Sudhin Thanawala, *At Abortion Clinics, New Laws Sow Confusion, Uncertainty*, AP News (May 21, 2019),

confusion will proliferate nationwide, making it difficult, if not impossible, for public health officials and providers to share accurate information and provide the full spectrum of care to their patients.

B. As in the Era Before *Roe*, Abortion Bans Will Leave Low-Income Women and Women of Color Closed Off from Abortion Access Relative to White Women with Means

Although the delivery of abortion care and safety of self-managed abortion has changed drastically in the half-century since *Roe v. Wade* was decided, many of the disparities in reproductive health care for women of color and low-income women persist. Before *Roe* was decided, lower-income (and typically nonwhite) women died at alarming rates in dangerous, illegal procedures while their wealthier counterparts were more likely to travel to places where abortion was legal or to influence private physicians to perform abortions for them. These disparities would be exacerbated by a decision that drastically changes abortion access. Because women with low incomes and women of color often face delays in accessing abortion care, any compromise to pre-viability standards will cause health disparities to become more stark.

Roe v. Wade ensured that doctors and patients would not be subject to criminal penalties for providing or having an abortion. *Roe* thus standardized the patchwork of state criminal abortion bans in the United States and expanded abortion

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https://apnews.com/article/us-news-ap-top-news-laws-huntsville-ms-state-wire-aad4cc8b68b7400aac27e5c1abc7b1be.

access that was previously available only to those with financial means. Indeed, before abortion was widely available in the United States, those with means traveled abroad to procure abortions at a cost well beyond what most women could afford.[85] For those hoping to stay closer to home, the cost of getting a "safe, competently performed abortion in a local hospital" was prohibitive for all but the most wealthy. As the *Washington Post* reported in 1966, a woman seeking a hospital abortion needed $600 (nearly $5,000 in today's dollars) to get two psychiatrists to attest that she was suicidal because of her pregnancy and a gynecologist to perform "therapeutic abortion [] for depression."[86]

After New York legalized abortion in 1970, hundreds of thousands of women traveled to New York City to access abortion. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the City of New York filed an amicus brief detailing the influx of out-of-state women desperately seeking an abortion in

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[85] *See, e.g.*, Linda Greenhouse & Reva Siegel, *Before* Roe v. Wade*: Voices That Shaped the Abortion Debate*, pp. 8-11 (2012) (reproducing instructions written by the Society for Humane Abortion for procuring an abortion in Japan, including that plane tickets would cost around $8,000 in today's dollars); *see* Consumer Price Index Inflation Calculator, U.S. Bureau Lab. Stats., https://www.bls.gov/data/inflation_calculator.htm.

[86] Elisabeth Stevens, *When Abortion Was Illegal: A 1966* Post *Series Revealed How Women Got Them Anyway*, Wash. Post (June 9, 2019), https://wapo.st/3tngYf0.

New York City.[87] The numbers revealed a stark reality: *over ninety percent* of those who traveled to New York City for an abortion between 1970 and 1973 were White. Wealth and race created a two-tiered system of abortion access in the decades before *Roe*: one for White women of means who could travel or influence their physicians to sign off on otherwise illegal abortions, and a much more dangerous tier for women of color and those without financial resources.

If *Roe* is compromised, the need for abortion will not disappear. Indeed, when Texas banned abortion at 20 weeks in 2013, neighboring states saw a two-fold increase in women from Texas crossing the border to obtain an abortion.[88] When Texas Governor Greg Abbott halted abortions during the COVID-19 pandemic, the Planned Parenthood serving Colorado saw a twelve-fold increase in Texas patients seeking an abortion.[89] As Texas's six-week abortion ban has gone into effect, clinics in surrounding states are already preparing to be overwhelmed.[90]

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[87] Brief for the City of New York et al. as *Amici Curiae*, *Planned Parenthood of Se. Pa. v. Casey* (No. 91-744, 91-902), 1992 WL 12006404.

[88] Sarah Raifman et al., *Border-State Abortions Increased For Texas Residents After House Bill 2*, 104 Contraception, No. 3 (Sept. 2021), https://www.contraceptionjournal.org/article/S0010-7824(21)00089-5/pdf.

[89] Madeleine Schmidt, *Colorado Advocates Are Helping Texans Get Abortions. Here's How.*, Colo. Times (Sept. 9, 2021), https://coloradotimesrecorder.com/2021/09/colorado-advocates-are-helping-texans-get-abortions-heres-how/39517/.

[90] Adam Edelman, *New Mexico Braces for Influx after Supreme Court Allows Texas Abortion Restrictions*, NBC News (Sept. 3,

The Iowa Supreme Court recently recognized that higher-income women may be able to access abortion care that remains unavailable to most other women:

> Abortion regulations impact different women in many different ways. Womanhood is not a monolith. There are few hurdles that are of level height for women of different races, classes, and abilities. There are few impositions that cannot be solved by wealth. Women of means are surely better positioned to weather the consequences . . . .[91]

Studies of abortion access following restrictive state abortion regulations foreshadow what a post-*Roe* landscape could look like for low-income women and women of color. For example, the effects of Texas's H.B. 2[92]—including decreased abortion access and an increase in travel distance of over 100 miles for an abortion—affected Hispanic women significantly more than White women.[93] More recently, the fallout from

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2021), https://www.nbcnews.com/politics/politics-news/new-mexico-braces-influx-after-supreme-court-allows-texas-abortion-n1278362.

[91] *Planned Parenthood of the Heartland v. Reynolds ex rel. State*, 915 N.W.2d 206, 232 (Iowa 2018) (striking down 72-hour waiting period for abortion).

[92] Texas's H.B. 2, the subject of *Whole Woman's Health v. Hellerstedt*, imposed requirements that resulted in half of Texas's abortion providers shutting down. 136 S. Ct. at 2313.

[93] Vinita Goyal et al., *Differences in Abortion Rates by Race–Ethnicity After Implementation of a Restrictive Texas Law*, 102 Contraception, No. 2 (Apr. 15, 2020), https://www.contraceptionjournal.org/article/S0010-7824(20)30111-6/fulltext

Texas's S.B. 8, which bans all abortion after six weeks, demonstrates the chaos and difficulty in accessing abortion that could await women well beyond Texas. As S.B. 8's effective date loomed, pregnant women sought information and care from clinics in at least Colorado, Kansas, Minnesota, New Mexico, and Oklahoma.[94] When S.B. 8 went into effect, the average one-way driving distance to the nearest abortion clinic increased *twenty-fold*. And, because the neighboring states nearest to most Texans (Louisiana and Oklahoma) also restrict abortion access, many pregnant women will need to travel even farther.[95] If *Roe* is overturned, there will likely be enormous swaths of the country where abortion access by anything other than air travel is nearly impossible.

("The abortion rate also decreased more among those living in a county with an HB2-related clinic closure, especially for Hispanic women [-41% Hispanic vs. -29% White vs. -30% Black vs. -3% Other]. Hispanic women whose travel distance increased 100+ miles had the greatest reduction in the abortion rate [-43%].").

[94] Neelam Bohrum, *Abortion Providers and Distraught Patients Confront Stark Realities of Texas' New Law*, Tex. Tribune (Sept. 1, 2021), https://www.texastribune.org/2021/09/01/texas-abortion-law-clinics-patients/; Shefali Luthra, *After the Texas Abortion Ban, Clinics in Nearby States Brace for Demand*, The Guardian (Sept. 2, 2021), https://www.theguardian.com/us-news/2021/sep/02/as-texas-patients-prepare-to-travel-hundreds-of-miles-for-abortion-access-out-of-state-clinics-brace-for-surge.

[95] E. Nash et al., *Impact of Texas' Abortion Ban: A 20-Fold Increase in Driving Distance to Get an Abortion*, Guttmacher Inst. (last updated Sept. 15, 2021), https://www.guttmacher.org/article/2021/08/impact-texas-abortion-ban-20-fold-increase-driving-distance-get-abortion.

In sum, upholding the Mississippi Ban—whether by overruling *Roe* or by otherwise compromising the fundamental abortion right *Roe* promised—will inevitably lead to legal uncertainty and insurmountable logistical hurdles surrounding abortion care. *Amici*'s role and responsibilities as caretakers of public health and overall well-being will be significantly affected, and ongoing efforts to address persistent health disparities will be compromised.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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