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 ABORTION FUNDS AND PRACTICAL SUPPORT ORGANIZATIONS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICI CURIAE

Amici are nonprofit organizations that provide much-needed financial and practical support to vulnerable people seeking abortion care throughout the United States.[1] *Amici* offset the cost of abortion care for patients living in poverty, drive patients to and from abortion appointments when they lack reliable or affordable transportation to distant locations, arrange for overnight lodging so patients need not sleep in their cars or at transport centers between appointments, secure legal representation for young people whose inability to obtain parental consent for an abortion forces them to petition a local judge for a bypass of the requirement—and perform countless other services in response to the urgent and complex needs of marginalized people who no longer want to be pregnant.

Amici are committed to helping people access safe and legal abortion care regardless of their socioeconomic status, race or ethnicity, age, immigration status, geographic location, or disability. Accordingly, *Amici* oppose previability abortion bans and medically unwarranted regulations that prevent or significantly delay abortion access; force healthcare providers to deliver substandard care to abortion patients; or require abortion patients to engage in stigmatizing,

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[1] Pursuant to Rule 37.6, *Amici* state that no counsel for any party has authored this brief in whole or in part, and no person other than *Amici* or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. All parties have filed a blanket consent to the filing of amicus briefs.

degrading, or dangerous conduct as a precondition for abortion care.

As organizations that work to address the needs of people who would otherwise be unable to obtain an abortion—and are sometimes unable to do so even with the assistance of multiple abortion funds and practical support organizations—*Amici* have first-hand knowledge of the extensive barriers to abortion access that vulnerable communities in this country face and how restrictive abortion laws such as the fifteen-week ban at issue in this case exacerbate them.

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

INTRODUCTION AND SUMMARY OF ARGUMENT

This Court's abortion jurisprudence has consistently centered the experiences of people who would be most impacted by abortion restrictions. *See, e.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 894 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.); *Roe v. Wade*, 410 U.S. 113, 153 (1973). With respect to the restriction at issue here—Mississippi's law banning abortion beginning at fifteen weeks of pregnancy—the people most impacted are the small but stable group of abortion patients who obtain abortion care during the second trimester.[2] *Amici* have first-hand experience working with these patients to facilitate their access to abortion.

Both *Amici*'s experience and the published literature concerning abortion access demonstrate that persistent and formidable barriers routinely prevent some people from obtaining abortions before fifteen weeks of pregnancy. These barriers include: limited financial resources; systemic racism; later recognition of pregnancy; scarcity of abortion providers; logistical factors such as difficulty taking time off from work or

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[2] The second trimester begins at thirteen weeks of pregnancy. According to the U.S. Centers for Disease Control and Prevention, during the ten-year period from 2009 to 2018, which is the most recent decade for which data are currently available, the percentage of abortions performed during the second trimester "did not change appreciably." Katherine Kortsmit, *Abortion Surveillance—United States, 2018*, 69 MORBIDITY & MORTALITY WKLY. REP. 1, 8 (2020), https://www.cdc.gov/mmwr/volumes/69/ss/pdfs/ss6907a1-H.pdf.

school, caregiving responsibilities, and lack of access to reliable and affordable transportation; misinformation; restrictive state laws; disabilities and underlying health conditions; and harassment, intimidation, and violence at abortion clinic entrances. *Amici*'s clients typically experience multiple barriers simultaneously, and their impact is cumulative. Low-income people, people of color, and adolescents who lack parental support are disproportionately impacted by these barriers and are therefore more likely than others to experience prolonged delay in abortion access despite acting with urgency to obtain abortion care.

For most patients who have abortions at fifteen weeks of pregnancy or later, obtaining an abortion earlier in pregnancy simply would not be possible given their circumstances. Accordingly, for these individuals, there is no practical difference between banning abortion at fifteen weeks and banning abortion period.

ARGUMENT

I. PERMITTING STATES TO BAN ABORTION AT FIFTEEN WEEKS OF PREGNANCY WOULD PREVENT THEIR MOST DISADVANTAGED RESIDENTS FROM OBTAINING ABORTIONS.

This Court has rightfully placed vulnerable patients at the center of its abortion jurisprudence, focusing the "constitutional inquiry [on] the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894; *see also Roe*, 410 U.S. at 153. This requires examining the impact of a law on individuals struggling with unreliable employment, lack of savings, limited health insurance, geographic isolation, intimate partner violence, and similar hardships. In *Casey*, for example, the Court evaluated the burdens of a spousal notification requirement by focusing on "victims of regular physical and psychological abuse" rather than on women in "well-functioning marriages." 505 U.S. at 892-93. Likewise, in *Whole Woman's Health*, the Court highlighted the district court's finding that the challenged abortion restrictions "erect[ed] a particularly high barrier for poor, rural, or disadvantaged women." *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292, 2302 (2016) (citation omitted); *see also June Med. Servs. L.L.C. v. Russo*, 140 S.Ct. 2103, 2140 (2020) (Roberts, CJ., concurring) (considering how the need to travel increased distances to reach an abortion provider "would exacerbate th[e] difficulty" "Louisiana women already 'have . . . affording or arranging for transportation and childcare'" (citation omitted)).

Banning abortion at fifteen weeks of pregnancy, as Mississippi has done, will undoubtedly prevent states' most disadvantaged residents from obtaining abortions. *Amici*'s first-hand experience, which is consistent with published research findings, demonstrates that some people who seek abortion care face barriers to obtaining it that inevitably delay them past fifteen weeks' gestation. For these individuals, banning abortion at this stage of pregnancy is tantamount to requiring them to carry an unwanted pregnancy to term.[3]

II. THROUGHOUT THE UNITED STATES, PEOPLE FACE PERSISTENT AND FORMIDABLE BARRIERS TO OBTAINING ABORTION CARE BEFORE FIFTEEN WEEKS OF PREGNANCY.

Nearly everyone who has a second-trimester abortion was prevented from having an abortion earlier in pregnancy, even though that is what they would have preferred,[4] by persistent and formidable barriers to abortion access. For people affected by these barriers, there is no practical difference between banning abortion at fifteen weeks' gestation and banning abortion period.

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[3] *See* Ushma D. Upadhyay, et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 AM. J. PUB. HEALTH 1687, 1692 (2014), https://doi.org/10.2105/ajph.2013.301378 ("Findings from this study suggest that in 2008 more than 4000 women carried unwanted pregnancies to term after they were denied an abortion because of provider gestational age limits.").

[4] Lawrence B. Finer, et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 341 (2006), https://doi.org/10.1016/j.contraception.2006.04.010.

What follows is not an exhaustive list of factors that delay abortion access; rather, it is a description of barriers routinely encountered by the second-trimester abortion patients that *Amici* assist.

A. Limited Financial Resources

Having limited financial resources is a major barrier to abortion access. For people with little disposable income, it often takes time to save or raise enough money to pay for an abortion.[5] The cost of abortion care increases as pregnancy progresses, however. The average price of a first-trimester abortion is approximately $500; the average price of an abortion between fourteen and twenty weeks' gestation is approximately $750; and the average price of an abortion at 20 weeks' gestation or later is approximately $1,875.[6] Consequently, the longer it takes someone to secure the money to pay for an abortion, the more the procedure will cost, which can trap an abortion patient in a cycle of fundraising and delay.[7]

Abortion patients are more likely to experience financial hardship than the general public. Three-quarters of abortion patients in the United States are

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[5] Upadhyay, et al., *supra* note 3, at 1692.

[6] Sarah C.M. Roberts, et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 WOMEN'S HEALTH ISSUES e211, e214 (2014), https://doi.org/10.1016/j.whi.2014.01.003.

[7] Diana Greene Foster & Katrina Kimport, *Who Seeks Abortions at or After 20 Weeks?*, 45 PERSP. ON SEXUAL & REPROD. HEALTH 210, 214 (2013), https://doi.org/10.1363/4521013 ("For some women, raising money for the procedure took so long that by the time they had gathered enough money, their pregnancy had progressed to a stage that necessitated a more expensive procedure.").

poor or low-income: Nearly half live in households that are below the federal poverty level, and twenty-six percent live in households that earn 100%-199% of the federal poverty level.[8] Currently, the federal poverty level for an individual is an annual income of $12,880, and the federal poverty level for a family of four is an annual income of $26,500.[9]

Many abortion patients must pay for their abortions out of pocket because they lack health insurance coverage for abortion. The Hyde Amendment and related federal statutes prohibit abortion coverage for people who depend on the federal government for their health insurance, including people enrolled in Medicaid, Medicare, and the Children's Health Insurance Program ("CHIP"); civilian federal employees; military personnel and veterans; people imprisoned or detained by the federal government; Native Americans; Peace Corps volunteers; and low-income residents of the District of Columbia.[10] State laws add further limitations: Twenty-five states restrict abortion coverage in plans

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[8] Jenna Jerman, et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* 7 (May 2016), https://www.guttmacher.org/sites/default/files/ report_pdf/characteristics-us-abortion-patients-2014.pdf.

[9] U.S. Dep't of Health & Human Servs., *2020 Poverty Guidelines*, https://aspe.hhs.gov/2021-poverty-guidelines (last visited Sept. 17, 2021).

[10] *See* Guttmacher Inst., *The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion* 1-2 (May 2021), https://www.guttmacher.org/sites/default/files/factsheet/hyde-amendment-fact-sheet.pdf; Alina Salganicoff, et al., *The Hyde Amendment and Coverage for Abortion Services*, KFF (Mar. 5, 2021), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/.

offered through health insurance exchanges;[11] eleven states restrict abortion coverage in all private health insurance plans written in the state;[12] and twenty-one states restrict abortion coverage in health insurance plans for public employees.[13]

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[11] Ala. Code § 26-23C-3(a); Ariz. Rev. Stat. Ann. § 20-121(A); Ark. Code Ann. § 23-79-156(c)(1); Fla. Stat. §§ 627.64995(1), 627.66996(1), 641.31099(1); Ga. Code Ann. § 33-24-59.17; Idaho Code Ann. § 41-1848; Ind. Code Ann. § 16-34-1-8; Kan. Stat. Ann. § 40-2,190(b); Ky. Rev. Stat. Ann. § 304.5-160; La. Stat. Ann. § 22:1014(B); Mich. Comp. Laws § 550.542; Miss. Code Ann. § 41-41-99(1); Mo. Ann. Stat. § 376.805(3); Neb. Rev. Stat. Ann. § 44-8403(1); N.C. Gen. Stat. Ann. § 58-51-63(a); N.D. Cent. Code Ann. § 14-02.3-03; Ohio Rev. Code Ann. § 3901.87; Okla. Stat. Ann. tit. 63, § 1-741.3(A); 40 Pa. Cons. Stat. § 3302(a)-(b); S.C. Code Ann. § 38-71-238(A); S.D. Codified Laws § 58-17-147; Tenn. Code Ann. § 56-26-134; Tex. Ins. Code Ann. § 1696.002; Utah Code Ann. § 31A-22-726(3); Wis. Stat. Ann. § 632.8985(2). *See generally* Guttmacher Inst., *Regulating Insurance Coverage of Abortion* (Sept. 1, 2021), https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion.

[12] Idaho Code Ann. §§ 41-2142,-3439;-3924; Ind. Code §§ 27-8-13.4-2,-13-7-7.5; Kan. Stat. Ann. § 40-2,190(a); Ky. Rev. Stat. Ann. § 304.5-160; Mich. Comp. Laws Ann. § 550.543; Mo. Ann. Stat. § 376.805(1); Neb. Rev. Stat. Ann. § 44-8403(2); N.D. Cent. Code Ann. § 14-02.3-03; Okla. Stat. Ann. tit. 63, § 1-741.3(B); Tex. Ins. Code Ann. § 1218.004; Utah Code Ann. § 31A-22-726(2). *See generally* Guttmacher Inst., *supra* note 11.

[13] Ariz. Rev. Stat. Ann. § 35-196.02(B); Colo. Rev. Stat. Ann. § 25.5-3-106; Ga. Code Ann. § 45-18-4; Idaho Code Ann. § 41-2142; Ind. Code Ann. § 16-34-1-2; Kan. Stat. Ann. § 40-2,190(a); Ky. Rev. Stat. Ann. § 18A.225(10); Mich. Comp. Laws Ann. § 400.109a; Miss. Code Ann. § 41-41-91(a); Mo. Ann. Stat. § 188.205; Neb. Rev. Stat. Ann. §§ 44-1615.01; N.C. Gen. Stat. Ann. § 143C-6-5.5; N.D. Cent. Code Ann. §§ 14-02.3-01(3),-02; Ohio Rev. Code Ann. § 9.04; Okla. Stat. Ann. tit. 63, § 1-741.1(B); 18 Pa. Cons. Stat. § 3215; R.I. Gen. Laws Ann. § 36-12-2.1, *invalidated in part by Nat'l Educ. Ass'n of R.I. v. Garrahy*, 598 F. Supp. 1374, 1388 (D.R.I. 1984)

Although *Amici* provide financial assistance to abortion patients, they are generally able to cover only a fraction of the cost of abortion care. One study of data collected from thirty abortion facilities throughout the United States, which took into account financial assistance provided by abortion funds, found that the average out-of-pocket cost for an abortion was $474, and the average out-of-pocket cost for abortion-related travel was $54.[14] For more than half of the patients involved in the study, total out-of-pocket costs (including both abortion and travel), exceeded one-third of a patient's monthly income.[15] Not surprisingly, 54% of the sample reported that the need to raise money to pay for the abortion and related expenses delayed them from obtaining care, consistent with other research findings.[16]

(holding unconstitutional statutory provision prohibiting municipalities from using their own funds to provide employees with coverage for abortion care), *aff'd*, 779 F.2d 790 (1st Cir. 1986); S.C. Code Ann. §§ 1-1-1035; Tex. Ins. Code Ann. §§ 1218.002-.003; Utah Code Ann. § 76-7-331(2); Wis. Stat. Ann. § 40.56.

[14] Roberts, et al., *supra* note 6, at e214.

[15] *Id.*

[16] *Id.* at e215; *accord* Upadhyay, et al., *supra* note 3, at 1692 ("In this study, one of the primary reasons for delay in seeking an abortion was time spent raising the funds to pay for the procedure and travel."); Jessica W. Kiley, et al., *Delays in Request for Pregnancy Termination: Comparison of Patients in the First and Second Trimesters*, 81 CONTRACEPTION 446, 449 (2010), https://doi.org/10.1016/j.contraception.2009.12.021 ("Our findings demonstrate that many women experience substantial difficulty obtaining money to pay for their procedures, and this problem was more common among the second-trimester respondents."); Finer, et al., *supra* note 4, at 341-42 ("[S]econd-trimester patients were significantly more likely to indicate that they were delayed

A recent report published by the Board of Governors of the Federal Reserve System found that 35% of adults in the United States do not have enough cash on hand to pay for an unexpected expense of $400,[17] and that "[o]ut-of-pocket spending for health care is a common unexpected expense that can be a substantial hardship for those without a financial cushion."[18]

Amici's first-hand experience confirms that the cost of abortion care is a huge barrier to access for many patients, which commonly delays those with the fewest financial resources beyond fifteen weeks' gestation. For example, Access Reproductive Care-Southeast ("ARC-Southeast"), which serves six states including Mississippi, and provides financial assistance to approximately 500 abortion patients per year, routinely assists people who cannot afford the cost of abortion care. Some patients cannot afford the cost of an abortion even after ARC-Southeast provides them with funding support.[19] Patients in this situation are often pushed past fifteen weeks while they try to gather additional funds.

In 2020, Our Justice, which operates an abortion assistance fund in Minnesota, typically provided $150 to $200 to first-trimester abortion patients and $300

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because they needed time to raise money for the abortion.").

[17] Bd. of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2020* 33-34 (May 2021), https://www.federalreserve.gov/publications/files/2020-report-economic-well-being-us-households-202105.pdf.

[18] *Id.* at 36.

[19] Supporting declarations by *Amici*'s representatives can be found at https://lawyeringproject.org/our-work/dobbs-v-jwho-amicus-brief/.

to $500 to second-trimester abortion patients. Yet the starting cost of a first-trimester abortion in Minnesota is $700, and the starting cost of a second-trimester abortion in Minnesota is $800. Even with support from Our Justice and partner organizations, Minnesota abortion patients sometimes spend weeks or months trying to gather the necessary funds to access care.

Similarly, gathering money to pay for abortion care is a huge burden for clients of the Texas Equal Access Fund ("TEA Fund") and consistently delays their ability to get care. All of TEA Fund's clients are low-income and the majority are either uninsured or have insurance such as Medicaid that does not provide abortion coverage. Although TEA Fund provided financial assistance to 1,218 Texans last year, that represents just one-quarter of the people who sought its help. Budgetary constraints prevented the organization from providing financial assistance to the remaining three-quarters of people who requested it.

Delays in abortion access caused by limited financial resources worsen in times of economic crisis. For example, since the start of the COVID-19 pandemic, ARC-Southeast has seen a rise in callers who need financial assistance because they lost their jobs or do not have steady employment.

B. Systemic Racism

Systemic racism is another barrier to abortion access that delays people from obtaining care. Systemic racism has contributed to severe and pervasive disparities in reproductive healthcare access and outcomes among racial and ethnic groups, including higher rates of unintended pregnancy, preterm birth, maternal

mortality, and breast, cervical, and endometrial cancer deaths among Black individuals.[20] A growing body of literature documenting these impacts has led leading professional organizations in the field of obstetrics and gynecology to acknowledge that "[d]ifferences in outcomes result from many factors, including racism and bias in access to and delivery of quality health care, and must be acknowledged and addressed."[21]

Systemic racism contributes to delays in abortion access for people of color, particularly those who are Black.[22] Nationwide, more than 60% of abortion patients are people of color, including 28% who are Black.[23] Relative to white individuals, Black individuals are significantly more likely to obtain an abortion in the second trimester of pregnancy.[24]

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[20] Am. Coll. of Obstetricians & Gynecologists, *Racial and Ethnic Disparities in Obstetrics and Gynecology*, 126 OBSTETRICS AND GYNECOLOGY e130, e131 tbl.1 (2015), https://doi.org/10.1097/aog.0000000000001213.

[21] Am. Ass'n of Gynecologic Laparoscopists, et al., *Joint Statement: Obstetrics and Gynecology: Collective Action Addressing Racism* (Aug. 27, 2020), https://www.acog.org/news/news-articles/2020/08/joint-statement-obstetrics-and-gynecology-collective-action-addressing-racism.

[22] Christine Dehlendorf, et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772, 1776 (2013), https://doi.org/10.2105/ajph.2013.301339.

[23] Jerman, et al., *supra* note 8, at 5.

[24] Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions*, 12 PLOS ONE e0169969, 12 (2017), https://doi.org/10.1371/journal.pone.0169969.

The vast majority of ARC-Southeast's clients are Black. Many come from cities or towns that do not have a single obstetrician-gynecologist ("ob-gyn"). Moreover, none of the states that the organization serves has adopted Medicaid expansion—a decision that disproportionately impacts the ability of people of color to access routine healthcare.[25] Lack of access to routine healthcare makes it more likely that people of color will be delayed in recognizing that they are pregnant and seeking an abortion.

Systemic inequalities also mean that *Amici's* clients of color, especially their Black clients, must struggle to overcome heightened financial and logistical obstacles to obtaining abortion care. For example, when *Amici*'s Black clients must drive long distances to access abortion care, they are at significantly greater risk than their white counterparts of being pulled over by the police.[26]

Amici's Indigenous clients feel the effects of systemic racism acutely. For example, clients of Indigenous Women Rising often live in regions that do not

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[25] *See* Madeline Guth, et al.*, Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care*, KFF (Sept. 30, 2020), https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/.

[26] *See, e.g.*, AJ Willingham, *Researchers Studied Nearly 100 Million Traffic Stops and Found Black Motorists Are More Likely to be Pulled Over*, CNN (March 21, 2019, 12:54 PM EDT), https://www.cnn.com/2019/03/21/us/police-stops-race-stanford-study-trnd/index.html; Libor Jany, *Hennepin County Report Finds Stark Racial Disparities in Traffic Stops*, STAR TRIB., Oct. 5, 2018, https://www.startribune.com/hennepin-county-report-finds-stark-racial-disparities-in-traffic-stops/495324581/.

have ob-gyns. The Abortion Fund of Arizona likewise serves Indigenous people whose reproductive health-care needs often go unmet. Further, because systemic inequalities have led the COVID-19 pandemic to disproportionately affect Tribal Nations, many have implemented stay-at-home orders, including curfews in some cases. While these measures have been helpful in curbing the pandemic's spread, they have compounded the challenges of accessing abortion care for people living on reservations.

C. Later Recognition of Pregnancy

Later recognition of pregnancy is a major barrier to obtaining abortion care before fifteen weeks' gestation.[27] A notable study concerning risk factors for second-trimester abortion concluded that "many women seeking second-trimester abortions simply lacked pregnancy symptoms or were unaware of their last menstrual period and therefore took a long time to recognize and test for pregnancy."[28] Adolescents are

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[27] Diana Greene Foster, et al., *Timing of Pregnancy Discovery Among Women Seeking Abortion*, CONTRACEPTION (forthcoming 2021) (manuscript at 1), https://doi.org/10.1016/j.contraception.2021.07.110 ("[W]e found that later recognition of pregnancy, beyond 10 weeks, sets off a cascade of delays."); Jones & Jerman, *supra* note 24, at 11; Foster & Kimport, *supra* note 7, at 212, 213 ("[W]omen seeking later abortions were generally much farther along when they discovered their pregnancy than were women seeking first-trimester abortions. . . . "); Finer, et al., *supra* note 4, at 343 ("[P]roblems in suspecting pregnancy were an important cause of delay.").

[28] Eleanor A. Drey, et al., *Risk Factors Associated with Presenting for Abortion in the Second Trimester*, 107 OBSTETRICS & GYNECOLOGY 128, 134 (2006), https://doi.org/10.1097/01.aog.0000189095.32382.d0.

particularly likely to be delayed in recognizing that they are pregnant.[29] Many factors may contribute to later recognition of pregnancy, including lack of sex education; low health literacy; lack of access to routine healthcare; and physical factors, such as lack of pregnancy-related symptoms, irregular menstrual cycles, use of hormonal contraceptives, and above-or below-average weight.[30]

Many clients of Kentucky Health Justice Network do not recognize right away that they are pregnant. This is especially true of clients who had little or no sexual and reproductive health education in school, and those who do not have access to reproductive healthcare on a regular basis. As Kentucky Health Justice Network's staff members have observed, people in these circumstances grow up not understanding their bodies, let alone the fundamentals of sex and pregnancy. Many do not realize that they are at risk of pregnancy and do not recognize its symptoms initially. These clients are typically at more advanced gestational ages when they first contact the organization for help.

Because many of the adolescents served by Jane's Due Process do not closely track their periods or have regular menstrual cycles, they often experience delayed recognition of pregnancy and underestimate the number of weeks that they have been pregnant. It is not uncommon for the organization's clients to believe that they are not yet six weeks' pregnant when, in fact, they are ten weeks' pregnant or farther along.

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[29] Finer, et al., *supra* note 4, at 338, 343.

[30] Foster, et al., *supra* note 27 (manuscript at 2-3, 5); Foster & Kimport, *supra* note 7, at 214; Finer, et al., *supra* note 4, at 343.

D. Scarcity of Abortion Providers

The scarcity of abortion providers in the United States is a significant factor that delays patient access to care. Eighty-nine percent of counties do not have an abortion clinic, and 38% of reproductive-age women live in those counties.[31] People living in at least twenty-seven cities with populations of 50,000 or more must travel more than one hundred miles to reach the nearest abortion provider.[32] This lack of abortion providers contributes to delay in two ways: First, in regions where demand for abortion care exceeds the capacity of abortion providers, patients experience long waits for appointments.[33] Second, in regions without an abortion provider, patients must travel outside of their community to reach one, and the need for such travel often delays access to care significantly.[34] One study of the impact of a Texas

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[31] Rachel K. Jones, et al., *Abortion Incidence and Service Availability in the United States, 2017* 7 (Sept. 2019), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf.

[32] Alice F. Cartwright, et al., *Identifying National Availability of Abortion Care and Distance from Major U.S. Cities: Systematic Online Search*, 20 J. MED. INTERNET RES. e186, 7 (2018), https://doi.org/doi:10.2196/jmir.9717.

[33] Kari White, et al., *Change in Second-Trimester Abortion After Implementation of a Restrictive State Law*, 133 OBSTETRICS & GYNECOLOGY 771, 776 (2019), https://doi.org/10.1097/aog.0000000000003183; Jenna Jerman, et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSP. ON SEXUAL & REPROD. HEALTH 95, 98 tbl.2 (2017), https://doi.org/10.1363/psrh.12024; Upadhyay, et al., *supra* note 3, at 1689.

[34] Jones & Jerman, *supra* note 24, at 12 ("Women who lived 50 or more miles from the facility where they obtained the abortion

law that halved the number of abortion clinics operating in the state found that the number of second-trimester abortions increased by 13% after the law took effect.[35] Further, fewer providers offer abortion after the first trimester, and the availability of abortion continues to decrease as gestational age increases. As a result, delay caused by abortion provider scarcity can have a compounding effect.[36]

Our Justice assists numerous people from across the upper Midwest who come to Minnesota seeking abortion care because of its limited availability in their home states. Yet, even in Minnesota, abortion providers are concentrated in metropolitan areas on the eastern side of the state, particularly the Twin Cities region. Similarly, the Abortion Fund of Arizona encounters many Arizona residents from rural parts of the state who must travel long distances to reach an abortion clinic. Indigenous Women Rising's clients face even greater challenges because there are no abortion providers on the vast reservations where they live. As a result, they must travel enormous distances to access abortion care. For example, most people who reside in the Navajo Nation must travel at least six hours to reach an abortion clinic. Arranging

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were more likely to be seeking second-trimester procedures compared to those who lived within 25 miles."); Jerman, et al., *supra* note 33, at 98 & tbl.2; Foster & Kimport, *supra* note 7, at 214; Kiley, et al., *supra* note 16, at 449-50.

35 White, *supra* note 33, at 777.

36 Nat'l Acads. of Scis., Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* 33 (2018), https://doi.org/10.17226/24950; Foster & Kimport, *supra* note 7, at 214.

for such lengthy travel often takes time, causing significant delays in access to care.

E. Logistical Factors

Logistical factors are a significant source of delay in accessing care for many abortion patients. A study examining causes of delay among people who have abortions at twenty weeks' gestation or later found that, "[o]nce participants decided to have an abortion, logistics often complicated their ability to obtain the procedure."[37] Relevant logistical factors include difficulty taking time off from work or school, caregiving responsibilities, and lack of access to reliable and affordable transportation.[38]

Many of *Amici*'s clients have low-wage jobs that are inflexible and do not offer paid sick days. As a result, it is difficult for them to take time off to have an abortion without jeopardizing their employment or their ability to pay monthly bills. The inability to control their own schedules is one of the biggest barriers that clients of Jane's Due Process face. Adolescents with unsupportive or abusive parents, most are students. It is generally difficult for them to miss school or be away from home to visit an abortion provider without threatening the confidentiality surrounding their pregnancy and plans for an abortion. Waiting for an opportune time to make the necessary clinic visits is often a source of delay.

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[37] Foster & Kimport, *supra* note 7, at 214.

[38] Upadhyay, et al., *supra* note 3, at 1689; Kiley, et al., *supra* note 16, at 449; Finer, et. al, *supra* note 4, at 342.

Caregiving responsibilities also meaningfully delay abortion access. Most abortion patients are parents. Nearly 60% of them have previously given birth to a child, and one-third have given birth to two or more children.[39] Abortion patients frequently cite the need to secure childcare as a factor that delays abortion access.[40] Having responsibility for the care of elderly or disabled family members can similarly cause delays.

Many of *Amici's* clients are caregivers. For instance, most of All-Options' clients have young children. Because of Indiana's waiting-period law, Ind. Code § 16-34-2-1.1, they typically have to visit an abortion clinic on two separate days. Most of them cannot afford two days of childcare and must therefore delay their abortion while they try to raise the extra money. Even when they have family or friends nearby, they often cannot rely on them to provide childcare without disclosing their plans to have an abortion, which is not a viable option for many.

Similarly, it is common for Indigenous Women Rising's clients to live in multigenerational households where they are caring for a grandparent, child, or other relative. They must coordinate finding coverage for their caregiving responsibilities, often for multiple days, so they can travel to their appointments and satisfy state waiting period laws. The difficulty of finding a temporary caregiver often results in these individuals delaying their abortion care.

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[39] Jerman, et al., *supra* note 8, at 7.

[40] Jerman, et al., *supra* note 33, at 98 tbl.2; Finer, et al., *supra* note 4, at 342, 343.

Finding reliable transportation is another common logistical barrier and frequent cause of delay for abortion patients. For *Amici's* clients, finding a ride, access to a reliable car, and/or money for gasoline is often a significant challenge. Further, for those who are undocumented or whose families, friends, or partners are undocumented, the risk of encountering immigration checkpoints compounds transportation challenges.

Finding reliable transportation can be especially challenging for adolescents going through the judicial bypass process—*i.e.*, court proceedings through which adolescent abortion patients request exemption from statutory parental consent or notification requirements. For instance, clients of Jane's Due Process need reliable transportation for several different trips: an initial trip to an abortion clinic for an ultrasound and options counseling, a trip to the courthouse for a judicial bypass hearing, and, if the bypass is granted, at least one trip back to the clinic for abortion care. If transportation for even one of those trips falls through, it can require the patient to reschedule subsequent appointments, resulting in substantial, cascading delays.

Logistical barriers to abortion access are heightened when *Amici's* clients must travel outside their home state to obtain care. For example, second-trimester abortion services are unavailable in Indiana, except in very limited circumstances, so All-Options has helped hundreds of low-income abortion patients travel out of state for second-trimester procedures. As its staff members have observed, arranging out-of-state travel is often far more complex and expensive than arranging in-state travel and leads to longer delays in obtaining care. Unfortunately, despite *Amici's*

assistance, many people seeking abortion care are simply unable to overcome the logistical barriers to out-of-state travel. This is often the case for adolescents, like those served by Jane's Due Process, who cannot rely on their parents for support.

F. Misinformation

Misinformation is a common barrier to abortion access that delays receipt of care.[41] Many people seeking abortion care do not know where to obtain it or even whether and to what extent it is legal in their home state. Internet searches frequently produce inaccurate or unreliable information about the identity and location of abortion clinics,[42] and many healthcare providers are unwilling or legally unable to refer patients to abortion providers.[43] The stigma surrounding abortion exacerbates the difficulty in obtaining accurate information about the availability of abortion services because it deters people from discussing the subject openly. One study found that, "[a]lthough abortion is a common experience among reproductive-aged women

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41 Megan L. Kavanaugh, et al., *"It's Not Something You Talk About Really": Information Barriers Encountered by Women who Travel Long Distances for Abortion Care*, 100 CONTRACEPTION 79, 82 (2019), https://doi.org/10.1016/j.contraception.2019.03.048; Jerman, et al., *supra* note 33, at 98 tbl.2; Upadhyay, et al., *supra* note 3, at 1689 (citing "not knowing where to find abortion care" and "not knowing how to get to a provider" as common factors that delayed abortion access for study participants).

42 Kavanaugh, *supra* note 41, at 82.

43 *Id.* at 81-82; *see* 42 C.F.R. § 59.14(a) ("A Title X project may not perform, promote, refer for, or support abortion as a method of family planning, nor take any other affirmative action to assist a patient to secure such an abortion.").

in the United States, abortion stigma perpetuates an environment in which accurate information and clear linkages to care are obfuscated."[44] Further, many crisis pregnancy centers actively disseminate misinformation about abortion and/or pose as abortion clinics to divert people seeking abortion care away from genuine abortion providers.[45] Research has demonstrated that abortion patients who mistakenly visit a facility that does not provide the services they seek are significantly delayed in obtaining an abortion.[46]

Many of *Amici's* clients face delays that stem from misinformation. For example, misinformation about

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[44] Kavanaugh, *supra* note 41, at 82 (citation omitted).

[45] Am. Coll. of Obstetricians & Gynecologists, *Increasing Access to Abortion*, 136 OBSTETRICS AND GYNECOLOGY e107, e112 (2020), https://doi.org/10.1097/aog.0000000000004177; Kavanaugh, *supra* note 41, at 80, 81; Amy G. Bryant, et al., *Crisis Pregnancy Center Websites: Information, Misinformation and Disinformation*, 90 CONTRACEPTION 601, 603 (2014), https://doi.org/10.1016/j.contraception.2014.07.003; *see also Choice Inc. of Tex. v. Graham*, No. 04-cv-1581, 2005 WL 1400408, at *5 (E.D. La. June 3, 2005) (certifying a plaintiff class of "all persons who have been or will be subject to the misleading, deceptive, and tortious acts allegedly committed by the defendant" who impersonated an abortion clinic agent for the purpose of delaying patients' access to abortion past the legal gestational cutoff in Louisiana); *Fargo Women's Health Org., Inc. v. Larson*, 381 N.W.2d 176, 177 (N.D. 1986) (affirming entry of a preliminary injunction against a crisis pregnancy center engaged in false and deceptive advertising about the services it offered).

[46] Finer, et al., *supra* note 4, at 340 ("Notably, women who went to another clinic took over twice as long, on average, between initially attempting to make an appointment and obtaining the abortion."); Drey, et al., *supra* note 28, at 130 ("An initial referral elsewhere was the single most frequently reported delay-causing factor by second-trimester patients (47%).").

abortion care is pervasive in the Indigenous community served by Indigenous Women Rising. Often, people who live on reservations are not aware that they cannot obtain abortion care through the Indian Health Service ("IHS"). They expend time and resources to make an appointment at an IHS clinic or hospital, only to learn once they arrive that federal law prevents their health system from providing them with the care that they seek. *See generally* 42 C.F.R. §§ 136.51–136.57.

Further, deceptive advertising leads some of *Amici's* clients to seek abortion care at crisis pregnancy centers. Our Justice has tallied ninety-three crisis pregnancy centers in Minnesota, with an expansive reach. Sometimes weeks go by before *Amici*'s clients realize that a crisis pregnancy center has been stringing them along. In addition, some crisis pregnancy centers provide *Amici*'s clients with inaccurate information about the results of ultrasound examinations, leading them to believe that they are earlier in pregnancy than they really are. This sometimes causes them to seek care at an abortion clinic that does not provide the type of services they need, leading to further delay.[47]

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[47] *See generally* Nat'l Acads. of Scis., Eng'g & Med., *supra* note 36, at 159-60 ("Four legal abortion methods . . . are used in the United States. Length of gestation . . . is the primary factor in deciding what abortion procedure is the most appropriate."); Upadhyay, et al., *supra* note 3 at 1687 (explaining that abortion clinics set varying limits on maximum gestational age based on clinician training, competence, and comfort level as well as state regulations).

G. Restrictive State Laws

In many states, abortion restrictions create barriers to abortion access that delay patients from obtaining care. The American College of Obstetricians and Gynecologists has noted that "[r]ecent years have seen a dramatic increase in the number and scope of legislative measures restricting abortion."[48] In its recent consensus study report on *The Safety and Quality of Abortion Care in the United States*, the National Academies of Sciences, Engineering, and Medicine found that "[s]tate regulations that require women to make multiple in-person visits and wait multiple days delay the abortion."[49] Likewise, "[r]estrictions on the types of providers and on the settings in which abortion services can be provided also delay care by reducing the availability of care."[50] In addition, many legal restrictions delay access to abortion by increasing the cost of obtaining care.[51]

For example, waiting-period laws in Alabama, Mississippi and Tennessee—*see* Ala. Code § 26-23A-

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[48] Am. Coll. of Obstetricians & Gynecologists, *supra* note 45, at e108.

[49] Nat'l Acads. of Scis., Eng'g & Med., *supra* note 36, at 78.

[50] *Id.* at 78; *accord* Am. Coll. of Obstetricians & Gynecologists, *supra* note 45, at e109 ("[Targeted Regulation of Abortion Provider] laws make abortion inaccessible for some people and create delays for others, leading to an increase in abortion after the first trimester.").

[51] Nat'l Acads. of Scis., Eng'g & Med., *supra* note 36, at 77-78; Am. Coll. of Obstetricians & Gynecologists, *supra* note 45, at e109 ("These laws make abortion more difficult and costly to obtain, imposing additional costs on the patients who can least afford them.").

4; Miss. Code Ann. § 41-41-33; Tenn. Code Ann. § 39-15-202(d)—often add weeks to the time it takes ARC-Southeast's clients to obtain an abortion because they are unable to take two days off from work, school, or caregiving responsibilities in the same week. In Arizona, a ban on the use of telemedicine in abortion care, Ariz. Rev. Stat. Ann. § 36-3604, delays access to abortion for clients of the Arizona Abortion Fund. In Texas, a host of restrictive abortion laws micromanage every aspect of the provision of abortion care. *See, e.g.*, Tex. Health & Safety Code §§ 171.003 (prohibiting qualified advance practice clinicians from providing abortions), 171.012 (imposing a mandatory waiting period on abortion patients); Tex. Occ. Code §§ 111. 005(c) (prohibiting the use of telemedicine in abortion care), 164.052(a)(19) (prohibiting abortion for minors without parental consent); 25 Tex. Admin. Code §§ 139.1–139.60 (imposing burdensome and medically unnecessary operating requirements on abortion clinics). For clients of TEA Fund and Jane's Due Process, the cumulative impact of these restrictions substantially delays access to abortion—often by weeks or months.

State abortion laws requiring parental involvement in adolescents' abortion care also cause delay.[52] Jane's Due Process and All-Options have observed that the judicial bypass process often delays their clients' ability to obtain abortion care by at least ten days, and in some cases, much longer.

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52 Am. Acad. of Pediatrics, *The Adolescent's Right to Confidential Care When Considering Abortion*, 139 PEDIATRICS 1, 5 (2017), https://pediatrics.aappublications.org/content/pediatrics/139/2/e20163861.full.pdf.

H. Disabilities and Underlying Health Conditions

Pregnant people with disabilities face additional obstacles to obtaining abortion care. For some, it is a challenge to find abortion clinics that are accessible and accommodating. In addition, finding transportation to and from appointments is more difficult for people who are disabled.

Moreover, patients with certain underlying health conditions have fewer options for where they can obtain abortion care. For example, some abortion providers are not equipped to treat people who are classified as obese. As Indigenous Women Rising's staff members have observed, many Indigenous people live in communities that do not have grocery stores or other healthy food options. Commonly called "food deserts," these communities' options for sustenance are more likely to be high in calories and low in nutrition. As a result, Indigenous people disproportionately struggle with chronic health issues stemming from unhealthy food options, which limits their options for abortion care.

In addition, many common maternal and fetal health conditions do not develop or are not typically diagnosed until after fifteen weeks of pregnancy.[53] For example, many serious pregnancy-related complications, such as pregnancy-induced hypertension and placental abnormalities, do not manifest until later

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[53] *Abortions Later in Pregnancy*, KFF (Dec. 5, 2019), https://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/; Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 AM. J. PUB. HEALTH 623, 624 (2009), https://doi.org/10.2105/ajph.2007.127530.

in pregnancy.[54] Likewise, structural fetal anomalies are typically not detected until twenty weeks of pregnancy, when most obstetricians perform a fetal anatomy scan.[55] A person seeking to end their pregnancy because of one of these conditions would not have the option of doing so at an earlier gestational age.

I. Harassment, Intimidation, and Violence at Abortion Clinic Entrances

Acts of harassment, intimidation, and violence at abortion clinic entrances serve as barriers to abortion access that cause patients to delay obtaining care.[56] Common acts of harassment and intimidation include "picketing with physical contact or blocking, vandalism, . . . bomb threats, harassing phone calls, noise disturbances, taking photos or videos of patients and staff, tampering with garbage, placing glue in locks or nails on the driveway of clinics, breaking windows, interfering with phone lines, approaching cars, and recording license plates."[57] Shootings and bombings occur less frequently, but still with chilling regularity.[58] Enforcement of the Freedom of Access

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[54] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 217 (2012); https://doi.org/10.1097/aog.0b013e31823fe923.

[55] *Abortions Later in Pregnancy*, *supra* note 53.

[56] Upadhyay, *supra* note 3, at 1689 (noting that study participants cited "fear of protestors" as a factor that delayed their access to abortion).

[57] Am. Coll. of Obstetricians & Gynecologists, *supra* note 45, at e111.

[58] *See* Liam Stack, *A Brief History of Deadly Attacks on Abortion*

to Clinic Entrances ("FACE") Act, 18 U.S.C. § 248, is inconsistent and has failed to stem the tide of harassment, intimidation, and violence outside abortion clinics.[59]

Fear of such activity is a big concern for clients of Kentucky Health Justice Network. The streets surrounding Kentucky's two abortion clinics are regularly occupied by anti-abortion activists who create a chaotic and threatening atmosphere for patients trying to enter the clinics. Local police officers are either unable or unwilling to keep the peace outside the clinics and sometimes join activists in harassing and demeaning patients trying to make their way through the sea of people blocking clinic entrances. Some of Kentucky Health Justice Network's clients delay their procedures because they are afraid of being doxed, grabbed, or screamed at by anti-abortion activists. Others try to obtain care out of state, which delays their abortion access while they attempt to raise the money and make the arrangements needed for such travel.

Patients at Minnesota abortion clinics must also contend with frightening harassment and intimidation tactics on a routine basis. A sea of anti-abortion activists often yell hateful expletives and misogynistic insults while physically invading the space of people trying to enter these healthcare facilities. One clinic faced an environment that was so harmful to patient

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Providers, N.Y. TIMES, Nov. 29, 2015, https://nyti.ms/2jQBSkI (noting that "[a]t least 11 people have been killed in attacks on abortion clinics in the United States since 1993").

59 Am. Coll. of Obstetricians & Gynecologists, *supra* note 45, at e111.

well-being, it installed a fence to provide its patients with privacy on their walk from the parking lot to the clinic entrance. In response, anti-abortion activists erected a deer stand from which they continue to harass patients trying to enter the clinic. At another clinic, anti-abortion activists routinely trespass onto clinic property, shouting at abortion patients through makeshift megaphones. Unsurprisingly, the atmosphere of terror created by this conduct leads some of Our Justice's clients to delay their abortions as they gather the courage to face those trying to prevent them from accessing the care that they seek.

III. THE IMPACT OF THESE BARRIERS IS CUMULATIVE AND FALLS DISPROPORTIONATELY ON CERTAIN GROUPS.

The barriers described above do not exist in isolation. *Amici*'s clients typically experience multiple barriers simultaneously, and their impact is cumulative.[60] Moreover, low-income people, people of color, and adolescents who lack parental support are disproportionately affected by these barriers. People in these groups are more likely than others to experience prolonged delays in access to wanted abortion care.

For the small but stable percentage of patients who obtain abortions after the first trimester, a fifteen-week ban would serve as a total abortion ban. That is because the factors that prevent these patients from

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60 *Cf.* Jerman, et al., *supra* note 33, at 98; Drey, et al., *supra* note 28, at 130 (noting that second-trimester patients in the study group "reported more than 3 delaying factors" on average).

obtaining abortion care earlier in pregnancy are largely beyond their control.[61]

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61 *See* Foster, et al., *supra* note 27 (manuscript at 6) ("Backers of gestational limits may assume that people are delaying their search for abortion services for reasons that are in their control. Yet we find that many people who seek abortion services later in pregnancy seek care as expeditiously as they can after discovering that they are pregnant.").

CONCLUSION

The decision below should be affirmed.

Respectfully submitted,

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SEPTEMBER 20, 2021

APPENDIX
LIST OF AMICI CURIAE

A Fund, Inc. provides financial support to Kentucky people seeking abortion services in Kentucky and the surrounding states. We were founded in 1993.

Abortion Fund of Arizona (AFAZ) launched in 2017 as a program of Pro-Choice Arizona. We are the only state-wide fund providing financial assistance and practical support to anyone seeking abortion care in Arizona.

Abortion Rights Fund of Western Mass provides funding and practical support for abortion access in Western Massachusetts and beyond, in partnership with local and national organizations. Founded in 1988, we are an all-volunteer organization committed to reproductive access.

Access Reproductive Care-Southeast (ARC-Southeast) is a reproductive justice organization that provides abortion funding and practical support to people seeking care in Alabama, Georgia, Florida, Mississippi, South Carolina and Tennessee. Founded in 2015, we also build power in communities of color to abolish stigma and restore dignity and justice.

ACCESS REPRODUCTIVE JUSTICE removes barriers to sexual and reproductive Health care and builds the power of Californians to demand health, justice, and dignity. We were founded in 1993.

All-Options believes everyone should have the support and resources they need to make the reproductive decisions that are right for them. We provide judgment-free support for pregnancy, parenting, abortion, and adoption to people throughout the United States.

In Indiana, we also provide abortion funding through the Hoosier Abortion Fund, as well as diapers, menstrual products, and more to ensure Hoosiers can access the care they need with dignity and without delay.

Apiary is a national membership collective by and for groups that provide practical support to abortion patients. We provide operational, programmatic, and community support tailored to the particularities, complexities, and concerns of abortion access practical support organizations. We centralize information without centralizing power.

Baltimore Abortion Fund (BAF) is a nonprofit organization that provides financial assistance to people who live in or travel to Maryland for abortion care. Founded in 2014, BAF operates a confidential helpline to make financial commitments for abortion procedures and to provide information on how to access abortion care.

The Bridge Collective has a mission to provide practical, responsive support for abortion services and reproductive healthcare resources for Central Texans. By mobilizing the power of volunteers, we strive to bridge the gap to ensure that all Central Texans have equal access to abortion care.

Carolina Abortion Fund helps people in North and South Carolina take charge of their futures, working to eliminate financial barriers to reproductive choice while providing emotional and practical support. We were founded in 2011.

Chicago Abortion Fund has a mission to advance reproductive autonomy and justice for everyone by providing financial, logistical, and emotional support to people seeking abortion services across the Midwest

and by building collective power and fostering partnerships for political and cultural change.

DC Abortion Fund is an all-volunteer, 501(c)(3) nonprofit that makes grants to pregnant people in the DC area, as well as those traveling to the area, who cannot afford the full cost of an abortion.

Emergency Medical Assistance (EMA) was founded in 1975 to provide practical support to people seeking abortion care in South Florida.

Florida Access Network builds pathways for abortion access by advocating for reproductive justice, funding abortion care, and providing logistical support to abortion seekers. We were founded in 1996.

Freedom Fund Inc. has been committed to reducing financial barriers to reproductive healthcare, including abortion services, for people across central and northern Wisconsin since 1998.

Frontera Fund was founded in 2015 and serves people in the Rio Grande Valley and Deep South Texas seeking abortion care. We provide practical support for those who must travel more than 100 miles to get their abortion care.

Fund Texas Choice is the only statewide practical support organization that provides equitable access to Texans to obtain comprehensive travel and logistical services in connection with their abortions. We were founded in 2013 in response to HB2.

Indigenous Women Rising serves Indigenous communities usually left out of conversations about reproductive and sexual health. We were founded in 2013 after the defeat of a twenty-week abortion ban.

Jane's Due Process helps minors in Texas navigate parental consent laws and confidentially access abortion and birth control. We are working towards a future where young people have full reproductive freedom and autonomy over their healthcare decisions.

Kentucky Health Justice Network builds the power of Kentuckians to achieve reproductive justice. We support this mission through direct support, education and outreach. Our work is guided by the reproductive justice framework. We believe reproductive rights are human rights, and that all people should be able to decide if, when, and how to parent.

Lilith Fund for Reproductive Equity provides direct financial assistance and emotional support to people seeking abortion care in the southeast and central regions of Texas. We were founded in 2001.

Mariposa Fund is a clinic-based abortion fund in Albuquerque, New Mexico, that helps undocumented people access abortion and contraception care.

Midwest Access Coalition provides holistic practical support for people traveling to, from, or within the Midwest seeking abortion care. We were founded in 2014.

National Network of Abortion Funds (NNAF) is a twenty-nine-year-old organization that builds power with members to remove financial and logistical barriers to abortion access by centering people who have abortions and organizing at the intersections of racial, economic, and reproductive justice. With over eighty member organizations and thousands of volunteers across the United States and abroad, NNAF is working

to ensure that every reproductive decision is supported and free from coercion.

New Jersey Abortion Access Fund (NJAAF) is a volunteer-run, 501(c)(3) organization that provides financial assistance to those seeking safe, legal abortions. We partner with providers and social service agencies in New Jersey to help people access the quality care they need and deserve. NJAAF provides grants to help cover the cost of an abortion or related services.

New York Abortion Access Fund supports anyone who is unable to pay fully for an abortion and is living in or traveling to New York State by providing financial assistance and connections to other resources.

North Dakota WIN Abortion Access Fund (WIN Fund) provides financial assistance for abortion and related reproductive healthcare services as well as logistical, appointment support in North Dakota. Our callers are from North Dakota, South Dakota, and Minnesota. Founded in 1999, the WIN Fund distributed $150,000 in assistance in 2020. We regularly fund people who need to travel out of North Dakota for care. We work to build stronger communities through funding and advocacy efforts in order to achieve reproductive justice.

Our Justice works to ensure that all people and communities have the power and resources to make sexual and reproductive health decisions with self-determination by providing financial and logistical support for abortion access. We envision a world free of reproductive oppression. Nothing less.

Reclaim has a mission to fuel individuals and communities to Reclaim their dignity around, confi-

dence in, and support of abortion and reproductive rights. Reclaim engages in advocacy and public education to provide accurate and thoughtful information on reproductive health in culture and society. Our MI Win Fund helps pregnant people overcome financial burdens in accessing abortion care in southeast Michigan. Since its inception, Reclaim has pledged and paid over $18,000 towards abortion care costs.

Stigma Relief Fund (SRF) is an abortion fund serving people who receive abortion care at any Whole Woman's Health or Whole Woman's Health Alliance clinic. SRF was created in 2004 as a 501(c)(3) nonprofit and is a member of the National Network of Abortion Funds. The fund provides financial support for those who cannot afford to pay the entire cost of an abortion and can also be used to fund practical support needs.

TBA Fund, Inc. d/b/a Tampa Bay Abortion Fund (TBAF) provides abortion funding and practical support to people seeking abortion services in or from Florida. We also provide support for residents from southern states and Texas, funding permitting.

Texas Equal Access Fund (TEA Fund) provides funding to low-income people in the northern region of Texas who are seeking abortion and cannot afford it, while simultaneously working to end barriers to abortion access through community education and shifting the current culture toward reproductive justice.

Tucson Abortion Support Collective (TASC) provides practical support, abortion funding, free emergency contraception, and support to minors seeking judicial bypass in Southern Arizona.

West Virginia Focus: Reproductive Education and Equity (WV FREE) builds stronger communities

through advocacy and education on reproductive health, rights and justice.

Women's Medical Fund, Inc. was founded in 1972 and supports residents in Wisconsin, where there is no Medicaid funding of abortion, by paying the partial cost, when needed, of abortion health care.

Women's Reproductive Rights Assistance Project (WRRAP) is the only independent, 501(c)(3) abortion fund that provides urgently needed financial assistance on a national level (all fifty states) to those seeking abortion or emergency contraception through our network of over 700 clinics. We were established in 1991.