No. 19-1392

IN THE
Supreme Court of the United States

THOMAS E. DOBBS, 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 CALIFORNIA WOMEN'S LAW CENTER AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Other Authorities

INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae California Women's Law Center ("CWLC") is a nonprofit law and policy center based in California whose mission is to create a more just and equitable society by breaking down barriers and advancing the potential of women and girls through transformative litigation, policy advocacy, and education. A vital part of CWLC's mission is fighting for reproductive health rights and justice by ensuring women have access to the health care opportunities they need to lead healthy and productive lives. CWLC believes that women and adolescent girls deserve both the right to make choices about their bodies and access to the full range of reproductive health options, regardless of geography or income level.

CWLC has an interest in opposing Mississippi's ban on pre-viability elective abortions to ensure that women and adolescent girls in California and around the country continue to have meaningful access to abortions. If the Court upholds Mississippi's ban on pre-viability elective abortions or allows states to enact more severe restrictions on pre-viability abortions that would be considered unconstitutional under the Court's current undue-burden framework, women who want abortions but are not able to access them in their home states will travel to states with fewer abortion restrictions, such as California, to

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[1] All parties to this case have filed blanket consents with the Court to allow submission of *amicus* briefs. Pursuant to this Court's Rule 37.6, this brief was not authored in whole or in part by counsel for any party, and no person or entity other than *amicus*, its members, or its counsel made a monetary contribution to fund the preparation or submission of this brief.

obtain abortions. Not only will such long-distance travel cause these people significant financial, psychological, and medical hardships, but demand for abortions at California clinics could exceed capacity if clinics are flooded with additional out-of-state patients. If that occurs, California clinics may not be able to offer timely and safe abortions to all people who seek their services, preventing both in-state and out-of-state patients from obtaining necessary care.

SUMMARY OF ARGUMENT

Petitioners ask the Court to declare that a state may prohibit pre-viability elective abortions subject only to rational basis review. Doing so would require the Court to overrule nearly a half-century of abortion precedents, beginning with *Roe v. Wade*, 410 U.S. 113 (1973), which have consistently re-affirmed the constitutionally protected right to a pre-viability elective abortion, invalidated outright bans on abortions, and approved restrictions on that right *only* if those restrictions do not pose an "undue burden." The Court should reject Petitioners' request and affirm the Fifth Circuit's holding that Mississippi's ban on pre-viability elective abortions after 15 weeks is unconstitutional.

If the Court permits states to intrude on a woman's right to choose an abortion pre-viability without this undue-burden analysis,[2] many individuals across the country—not only in Mississippi, but also in states like Texas, Arkansas, and Oklahoma that have already or likely will enact

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[2] This brief uses the term "women," but amicus recognizes that people of all gender identities may become pregnant and require abortion care.

similar (or harsher) prohibitions on pre-viability abortions—will effectively be left without a single option to receive abortions in their state. These women will likely be forced to travel long distances, at great personal, financial, medical, and emotional cost, to obtain abortions—and many may not be able to make the journey, or may not be able to do so in time. Even now, while the Court's longstanding abortion precedents remain intact, almost half the states have passed laws that seek to restrict the right to legal abortion. Nine of these states have enacted restrictions which have been determined to be unconstitutional under *Roe* but may be reinstated depending on the result of this case.[3] Upholding Mississippi's outright ban on abortion after 15 weeks' gestation will not only embolden states to pass similarly restrictive laws, but will also have the appearance of endorsing even more severe prohibitions—including Texas's now-effective ban on abortions after six weeks' gestation—which often functionally strip women of their right to an abortion.

Abortion access will be drastically reduced—or even extinguished—across entire regions of the country if the Court discards viability as the threshold for evaluating the constitutionality of abortion restrictions. The Court should therefore, at minimum, continue to reaffirm that restrictions that have the effect of increasing the need for long-distance travel for a large fraction of the women affected by those restrictions are unconstitutional. If, instead, the Court decides to do away with both its viability

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[3] *Abortion Policy in the Absence of Roe*, Guttmacher Institute, https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe (last visited Sept. 19, 2021).

threshold and accompanying undue-burden analysis, then it should, at the very least, continue to analyze if and how the restriction would affect the need for interstate travel. Without this backstop, the Court would move from permitting only pre-viability restrictions that satisfy its undue-burden test to allowing pre-viability restrictions *and* complete prohibitions—regardless of their significant travel-related burdens.

Pre-viability prohibitions on abortion like Mississippi's will not decrease demand for abortions, but will instead necessitate burdensome out-of-state travel for women who can no longer seek abortions in their home states, and that increased demand could, in turn, reduce access to abortions in states that do allow the procedure. Individuals who have to travel will be forced to incur significant financial costs associated with interstate travel (such as childcare, lost wages, lodging, and transportation, plus the cost of the procedure itself); bear heavy psychological burdens from being forced to seek out-of-state abortions and potentially disclose their situation to others; and face increased and unnecessary medical risk from having a delayed procedure. Moreover, these substantial burdens disproportionately affect women of color and those living in poverty. If a woman's ability to exercise her right to an abortion is tethered to her geography, travel and its effects must be central to the Court's framework. The Court should thus hold that abortion restrictions and prohibitions that result in significant increases in out-of-state travel—and accompanying heavy burdens—are unconstitutional.

ARGUMENT

I. PRE-VIABILITY PROHIBITIONS ON ABORTION ARE UNCONSTITUTIONAL WHERE THEY RESULT IN ONEROUS OUT-OF-STATE TRAVEL TO OBTAIN CARE.

A. The Court has consistently affirmed that having to travel long distances to receive abortions, and the costs associated with such travel, are substantial obstacles to abortion access.

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 877 (1992), the Court affirmed a woman's right to an abortion pre-viability, but it permitted states to impose *restrictions* on pre-viability abortions so long as those restrictions did not place an undue burden on one's ability to obtain an abortion. Since *Casey*, the Court has continued to evaluate abortion restrictions under this framework and, in so doing, has recognized that having to travel a significant distance to obtain care, along with the associated costs, constitute unconstitutional burdens.

For example, in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016), the Court confronted a Texas law that required physicians performing abortions to have admitting privileges at hospitals near the location of the abortion and required abortion facilities to meet standards applicable to ambulatory surgery centers. In ruling that these requirements posed an undue burden, the Court relied on record evidence demonstrating that after the provision went into effect, "the 'number of women of reproductive age living in a county … more than 150 miles from a provider increased from

approximately 86,000 to 400,000 … and the number of women living in a county more than 200 miles from a provider from approximately 10,000 to 290,000.'" *Id.* at 2313 (ellipses in original). In holding the same as to the surgical-center requirement, the Court stressed that the resultant clinic closures would "force women to travel long distances to get abortions in crammed-to-capacity superfacilities." *Id.* at 2318.

The Court also emphasized that the sharp decrease in the number of facilities as a result of the law (from about 40 to approximately 8), would lead to "fewer doctors, longer waiting times, and increased crowding." *Hellerstedt*, 136 S. Ct. at 2313. Specifically, it observed that where demand exceeds capacity, patients "are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered," as "[h]ealthcare facilities and medical professionals are not fungible commodities." *Id.* at 2318 (citation omitted).

In *June Medical Services LLC v. Russo*, 140 S. Ct. 2103, 2130 (2020), the Court struck down a Louisiana law imposing a nearly identical admitting-privileges requirement because it impermissibly "place[d] substantial obstacles in the path of women seeking an abortion in Louisiana," including in the form of increased travel distances of anywhere from one to five hours of driving. Chief Justice Roberts explained that increased travel distance would "exacerbate" the difficulty faced by Louisiana women with "affording or arranging for transportation and childcare on the days of their clinic visits." *Id.* at 2140 (Roberts, C.J., concurring in judgment) (citation omitted). Because Louisiana also required an ultrasound and mandatory counseling at least 24 hours before an abortion,

already lengthy travel time would be doubled or require patients to arrange for overnight lodging. *See id.* Worse still, "the burdens of this increased travel would fall disproportionately on poor women, who are least able to absorb them." *Id.* at 2130 (plurality op.). As in *Hellerstedt*, the Court reiterated that a substantial reduction in facilities "would inevitably mean 'longer waiting times, and increased crowding.'" *Id.* (quoting *Hellerstedt*, 136 S. Ct. at 2313).

Even when faced with increases in *intra*state travel caused by restrictions on abortion, the Court has (correctly) held that having to travel long distances imposes a "substantial obstacle" on abortion seekers. Broad prohibitions like Mississippi's outright ban after 15 weeks leave individuals without *any* meaningful abortion access in their state. The resultant interstate travel thus presents an even greater and more obvious undue burden. The magnitude of the associated costs of travel stemming from statewide prohibitions only reinforces this conclusion.

If the Court moves away from its undue-burden framework to some less demanding standard, it should not abandon its abortion precedent related to travel burdens entirely. Rather, the Court should continue to recognize—and disallow—increased burdens women face when they are forced to travel long distances to obtain abortions.

B. The Court has also long held that the number of women burdened by a restriction is central to assessing its constitutionality.

Since the undue-burden framework was first developed in *Casey*, the Court has reaffirmed that the number of women affected by an abortion law is essential to evaluating the law's constitutionality. There, in invalidating Pennsylvania's spousal-notification requirement, the Court emphasized that the requirement "will operate as a substantial obstacle to a woman's choice to undergo an abortion" "in a large fraction of the cases in which [it] is relevant." *Casey*, 505 U.S. at 895.

The Court adhered to this same "large fraction" approach in *Hellerstedt* and *June Medical*, determining that the challenged provisions placed "substantial obstacle[s] in the path of a large fraction of those women seeking an abortion for whom it is a relevant restriction," and were therefore unlawful. *June Medical*, 140 S. Ct. at 2133; *see also Hellerstedt*, 136 S. Ct. at 2320. Even where the Court has determined that a restriction did not violate the undue-burden test, it nevertheless affirmed the significance of this factor. *See Gonzales v. Carhart*, 550 U.S. 124, 167–68 (2007).

Notably, the restrictions in *Casey*, *Hellerstedt*, and *June Medical* did not necessarily apply to *all* women in the state seeking abortions. The states accordingly argued that the restrictions did not impose an undue burden because they did not satisfy *Casey*'s "large fraction" test. *Hellerstedt*, 136 S. Ct. at 2320; *see Casey*, 505 U.S. at 894–95; *June Medical*, 140 S. Ct. at 2132. The Court rejected these arguments, reiterating that "[t]he proper focus of constitutional

inquiry is the group for whom the law *is* a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894 (emphasis added); *June Medical*, 140 S. Ct. at 2132–33; *Hellerstedt*, 136 S. Ct. at 2320.

Where, as here, a statewide pre-viability ban will affect *all* individuals in the state seeking an abortion, the analysis is even simpler. If out-of-state travel caused by a pre-viability prohibition or restriction is found to be a substantial obstacle to abortion access, then it is unconstitutional under the Court's undue-burden framework. Even if the Court were to reduce its level of scrutiny to the likes of rational-basis review, this longstanding and critical factor should remain central to the Court's analysis.

II. PRE-VIABILITY PROHIBITIONS ON ABORTION WILL RESULT IN SHARP INCREASES IN TRAVEL DISTANCES FOR A LARGE FRACTION OF WOMEN.

A. Increased abortion restrictions do not lower demand but instead force women to travel out-of-state to obtain care.

While anti-abortion lawmakers may think that greater restrictions will curtail demand for abortions, this is not true. Studies have shown that demand for abortions does not decrease just because states implement harsher restrictions. Instead, the demand for abortion will likely remain steady while women simply experience delayed and/or less safe abortions.[4]

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[4] *See* Michael Nedelman, *Abortion Restrictions Don't Lower Rates, Report Says*, CNN (Mar. 21, 2018), https://www.cnn.com/2018/03/21/health/abortion-restriction-laws/index.html ("Laws that seek to limit abortions around the

As Kathy Kleinfeld, the director of a Houston-based abortion care provider, noted following Governor Greg Abbott's executive order restricting abortions in March 2020, "[n]ot a single woman [calling her clinic] has said[,] then I'll just go ahead and continue this pregnancy."[5] Rather, such restrictions lead those residents to seek abortions in states with fewer or no restrictions. Between 2012 and 2017, at least 276,000 people received abortions outside their home states because their home states had more severe abortion restrictions than the states they traveled to.[6] In 2020 alone, for example, Planned Parenthood clinics across California saw approximately 7,000 out-of-state patients.[7]

In that same period in New Mexico, roughly a quarter of the state's abortions were performed on out-of-state patients.[8] In contrast to neighboring

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world may not lower the rate of abortions but could make them less safe.").

[5] *See* Arielle Avila, *The State's Ban Isn't Stopping Texans from Getting Abortion*s, TexasMonthly (Apr. 13, 2020), https://www.texasmonthly.com/news-politics/texas-abortion-ban-coronavirus/.

[6] Christina A. Cassidy, *Women Seek Abortions Out of State Amid Restrictions*, AP (Sept. 8, 2019), https://apnews.com/article/in-state-wire-abortion-or-state-wire-il-state-wire-mo-state-wire-4ced42150e3348328296e28559c2143b.

[7] Iris Samuels, *New Texas Abortion Law Pushes Women to Out-of-State Clinics*, U.S. News & World Report (Sept. 2, 2021), https://www.usnews.com/news/health-news/articles/2021-09-02/new-texas-abortion-law-pushes-women-to-out-of-state-clinics.

[8] *See id.*

Texas, Arizona, and Oklahoma, New Mexico does not have any significant abortion restrictions, and it is one of only a handful of states to allow late-term abortions.[9] At some New Mexico clinics, as many as half of the patients might be traveling from Texas.[10]

As another example, Illinois saw an increase of 2,000 out-of-state abortion patients from 2018 to 2019.[11] Commentators have suggested this was likely the result of legislation enacted in neighboring Missouri in 2019, which banned abortions after eight weeks' gestation and imposed a slew of other restrictions (although the ban was blocked by court order).[12] By contrast, that same year, Illinois adopted legislation securing abortion as a "fundamental right" and preserving the legal status of abortion in the state, notwithstanding the fate of *Roe*.[13] These examples illustrate that states' adoption of severe abortion restrictions does not dissolve demand;

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[9] Colleen Heild, *New Mexico Becomes Abortion Magnet*, Albuquerque Journal (Mar. 20, 2016), https://www.abqjournal.com/743253/more-women-coming-to-nm-for-abortions.html.

[10] Alexa Garcia-Ditta, *With More Texans Traveling for Abortions, Meet the Woman Who Gets Them There*, Texas Observer (June 9, 2016), https://www.texasobserver.org/fund-texas-choice-new-mexico-abortion/.

[11] Angie Leventis Lourgos, *Abortions in Illinois Increased Almost 10% in One Year, with More than 7,500 Women Traveling Here From Out of State*, Chicago Tribune (May 28, 2021), https://www.chicagotribune.com/news/breaking/ct-illinois-abortion-numbers-increase-20210528-s5ddpbvcw5dk3ckwx5p5xv2d5m-story.html.

[12] *See id.*

[13] *See id.*

demand merely migrates to locations with fewer abortion restrictions.

B. Abortion limits adopted during the COVID-19 pandemic foreshadow the increased interstate travel that will result from pre-viability bans.

At the height of the COVID-19 pandemic, 11 states limited abortion access by defining abortion as a non-essential or elective procedure that could be suspended for the duration of the public health emergency.[14] Although some orders were successfully enjoined, and many were in effect only briefly, their impact was still quickly felt.

The effect of these bans illustrates how more permanent pre-viability prohibitions on abortion will precipitate greater increases in out-of-state travel. According to Planned Parenthood, clinics in Colorado, New Mexico, and Nevada reported a more than sevenfold increase in patients traveling from Texas between March 23 and April 14, 2020, when Texas's ban was in place.[15] Planned Parenthood Los Angeles also reported receiving a "huge influx of people from

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[14] Laurie Sobel et al., *State Action to Limit Abortion Access During the COVID-19 Pandemic*, Kaiser Family Foundation (Aug. 10 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/.

[15] Sarah McCammon, *After Texas Abortion Ban, Clinics in Other Southwest States See Influx of Patients*, NPR (Apr. 17, 2020), https://www.npr.org/sections/coronavirus-live-updates/2020/04/17/837153529/after-texas-abortion-ban-clinics-in-neighboring-states-see-influx-of-patients.

out of state" in spring 2020.[16] Even in the Midwest and South, where bans were adopted widely across the region, four facilities in Arkansas, Kansas, and Oklahoma reported collectively serving over 2,500 out-of-state patients between April 2020 and January 2021—a nearly 25% increase in out-of-state patients compared to the previous year.[17]

These measures were only temporary. If the Court allows states to permanently enact equally or more restrictive measures, the number of those seeking out-of-state care will only grow.

C. Sharp increases in travel distances will result from widespread adoption of pre-viability bans.

In 2021, laws restricting abortion have proliferated nationwide. By midyear, states had enacted 90 such laws—already surpassing the previous year-end record from 2011.[18] Among these 2021 enactments were numerous pre-viability prohibitions, including several *more severe* than the

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[16] Kyle Almond & Benazir Wehelie, *She Tried to Get an Abortion During the Pandemic. Her State Wouldn't Allow It*, CNN, https://www.cnn.com/interactive/2020/06/health/abortion-access-coronavirus-cnnphotos/ (last visited July 14, 2021).

[17] *See id.*

[18] *State Policy Trends at Midyear 2021: Already the Worst Legislative Year Ever for U.S. Abortion Rights*, Guttmacher Institute (July 1, 2021), https://www.guttmacher.org/article/2021/07/state-policy-trends-midyear-2021-already-worst-legislative-year-ever-us-abortion.

Mississippi restriction at issue here.[19] By contrast, California is one of only three states (plus the District of Columbia) that has not restricted abortion in 2021.[20]

As of the time of this writing, 22 states have passed laws that could be used to restrict legal abortions if the Court decides to overturn or roll back its decision in *Roe*, including 11 states with so-called "trigger bans," designed to ban all or nearly all elective abortions if *Roe* is overturned.[21]

If the Court were to allow pre-viability prohibitions on abortion, subject to some lesser standard than the current undue-burden framework, and all of these states moved to ban abortions entirely, the affected population (i.e., individuals of childbearing age for whom the distance to the nearest abortion facility would increase) would face an

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[19] Texas enacted a six-week ban, SB8, which took effect on September 1, 2021 after this Court denied the applicants' request for emergency relief. *Whole Women's Health v. Jackson*, No. 21A24, 594 U.S. ___, 2021 WL 3910722 (2021). The Department of Justice has since moved for an immediate injunction. *United States v. Texas*, No. 1:21-cv-00796-RP (W.D. Tex. Sept. 15, 2021), Dkt. 8. Arkansas and Oklahoma have banned abortion outright except to save a patient's life; Arkansas's ban has been blocked, though, and Oklahoma's will not take effect until November. Emma Batha, *U.S. States Making 2021 Moves on Abortion Rights and Access*, Thomson Reuters Foundation (Sept. 15, 2021), https://news.trust.org/item/20201231112641-qfynt/.

[20] Chloe Atkins, *What U.S. Abortion Access Looks Like, in Graphics*, NBC News (July 25, 2021), https://www.nbcnews.com/news/us-news/what-u-s-abortion-access-looks-graphics-n1274859.

[21] *See Abortion Policy in the Absence of Roe*, *supra* note 3.

increased average travel distance of *249 miles*—an approximately eight-hour round-trip drive.[22] Where neighboring states also are predicted to prohibit abortions, that number is significantly higher. For Mississippians, for example, that distance is 384 miles; for Texans, 492 miles.[23] Even for those living in states not likely to ban abortions, travel distances could still increase if their nearest facility is in a neighboring state that decides to ban the procedure or if their local facility is overcrowded by out-of-state travelers.

D. Increased demand in states with continued abortion access will require some women to travel even farther to obtain timely abortions.

As explained above, in states that have adopted or are slated to adopt severe abortion restrictions, there still remains a significant demand for abortions. If the Court holds that states can impose bans on pre-viability abortions, states that continue to offer such care will have to try and absorb that demand. But the volume of those who will need to look elsewhere for care will almost certainly exceed the capacity of nearby states to provide such care.[24]

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[22] Caitlin Myers et al., *Predicted Changes in Abortion Access and Incidence in a Post-*Roe *World*, 100 Contraception 367, 372 (2019).

[23] *See id.* at 368.

[24] There may also be clinic closures due to the Trump administration's rule forbidding Title X funding recipients from providing abortions or giving referrals for abortions, further limiting availability in states with fewer abortion restrictions. *See, e.g.*, Pam Belluck, *Planned Parenthood Refuses Federal*

In the West, where CWLC is located, Texas and Arizona are among those states that have expressed an interest in or already moved to prohibit access to some or nearly all elective abortions. Yet demand has remained inelastic. In Texas, even during the COVID-19 pandemic and in the face of the state effectively banning abortions between March and April 2020, providers performed nearly 54,000 abortions for Texas residents in 2020—only a slight decrease from 56,000 in 2019.[25] In Arizona in 2019, over 13,000 abortions were performed.[26]

If Texas and Arizona were to effectively ban abortions, these almost 70,000 women would not simply decide not to have an abortion; they would be forced to look to nearby states for care. Even if providers in neighboring New Mexico, Colorado, and Nevada could slightly increase their capacity, it is unlikely they would be able to accommodate all those from Texas and Arizona seeking abortions. These

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Funds Over Abortion Restrictions, N.Y. Times (Aug. 19, 2019). While the Biden administration has proposed a rule to reinstate Title X eligibility for these providers, the Trump-era rule remains in place. Sandhya Raman, *HHS Moves to Reinstate Aid to Family Planning Clinics that Perform Abortions*, Roll Call (Apr. 14, 2021), https://www.rollcall.com/2021/04/14/hhs-moves-to-reinstate-aid-to-family-planning-clinics-that-perform-abortions/.

[25] *Induced Terminations of Pregnancy*, Texas Health and Human Services Commission (last visited Aug. 24, 2021), https://www.hhs.texas.gov/about-hhs/records-statistics/data-statistics/itop-statistics.

[26] *Abortions in Arizona: 2019 Abortion Report*, Arizona Department of Health Services (Sept. 21, 2020), https://www.azdhs.gov/documents/preparedness/public-health-statistics/abortions/2019-arizona-abortion-report.pdf.

three states *combined* typically serve less than one-third of the patients currently obtaining abortions in Texas and Arizona.[27] With Texas otherwise flanked by states with equally or more restrictive abortion laws, many of the over 50,000 Texans who require an abortion each year will have to travel more than 1,000 miles to access care in California. Indeed, since Texas Senate Bill 8 ("SB8") went into effect, Planned Parenthood's California clinics have already seen an added two to three patients from Texas a day.[28] Should Arizona begin enforcing its pre-*Roe* restrictions, providers in neighboring California will see an influx of Arizonans in need of care, too.

As a result, providers in California, New Mexico, Colorado, and Nevada would see demand for services skyrocket, causing some out-of-state travelers to seek abortions in states even farther from home. Residents of California and other states that are expected to preserve abortion access may also face long distances to obtain timely care, due to overcrowding at their local clinics.

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[27] Katherine Kortsmit et al., *Abortion Surveillance — United States, 2018*, Centers for Disease Control and Prevention (Nov. 27, 2020), https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm.

[28] Molly Hennessy-Fiske, *For Many Texans, It's a Long Drive out of State for Abortion*, L.A. Times (Sept. 17, 2021).

III. TRAVELING OUT OF STATE FOR ABORTIONS IMPOSES SEVERE FINANCIAL, PSYCHOLOGICAL, AND MEDICAL BURDENS, WHICH DISPROPORTIONATELY AFFECT WOMEN OF COLOR AND THOSE LIVING IN POVERTY.

As the Court's precedent has consistently reflected, requiring women to travel outside their home state places a substantial burden on their right to access abortions. Traveling long distances also has severe and profound personal and financial impacts on people seeking abortions. Because "[a] simple measurement of distance traveled will not suffice to capture the personal impact that distance has on the individual seeking an abortion,"[29] the Court must consider these consequences—regardless of what standard the Court adopts going forward.

A. Many women seeking abortions outside their home state experience serious financial hardship.

As of 2014, the average out-of-pocket cost for an abortion was $474 and could be as high as $3,700.[30] Most of this cost is borne directly by the patient, because many abortion-seekers do not have medical

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[29] Jill Bar-Walker et al., *Experiences of Women Who Travel for Abortion*, PLOS ONE 15 (Apr. 19, 2019), https://doi.org/10.1371/journal.pone.0209991.

[30] *See* 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).

insurance,[31] and most insurance carriers do not cover the cost of an abortion procedure.[32]

In addition to paying for the procedure itself, women who are forced to travel to seek abortions must incur other related, significant costs, including transportation, lodging, childcare, and lost wages from taking time off work. One couple from Houston who traveled 13 hours to the nearest abortion clinic with availability in New Mexico during the pandemic paid $450 for the abortion itself, and more than $2,500 for the trip in full after factoring in gas, lodging, and meals.[33] They explained that this "was definitely an undue expense," and it had "been financially stressful in a time when you'd hope you wouldn't have to face" extra expenses.[34] Another woman explained that she traveled four hours to Atlanta to obtain her abortion because it was the only place with availability.[35] Her insurance would not cover her abortion, and she had

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[31] Sarah Varney, *Long Drives, Air Travel, Exhausting Waits: What Abortion Requires in the South*, NPR (Aug. 3, 2021), https://khn.org/news/article/abortion-in-south-requires-travel-long-waits/ (77% of 10,000 women seeking assistance from Atlanta-based abortion fund were uninsured or publicly insured).

[32] Bd. Governors Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2018*, at 21 (May 2019), https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf; Roberts et al., *supra* note 30.

[33] Avila, *supra* note 5.

[34] *Id.*

[35] Varney, *supra* note 31.

to take out a loan to cover the $1,100 in total costs for the procedure, gas, food, and medications.[36]

The cost of transportation alone can be prohibitive. Many women describe having to borrow money or a car, or rely on a friend or family member for transportation to their appointments because they cannot afford round-trip transportation on their own.[37] Workers at Feminist Women's Health Center in Atlanta regularly see patients from Alabama, Tennessee, Kentucky, and the Carolinas, who often have taken "long drives or flights" to get there.[38] The executive director of that center explained that some patients may only be able to get a ride to, but not home from, their center, requiring the center to assist in finding return transportation.[39] Of course, it is "much simpler to go 3 or 4 miles from your home" to have an abortion "and sleep in your bed at night," but that "is a luxury that so many of [their] patients can't enjoy."[40]

Women seeking abortions who already have children also have to find childcare before they can travel long distances to obtain an abortion. A patient educator and financial assistance coordinator at one of two abortion clinics in Memphis, Tennessee explained that, "[e]specially for women coming from long distances, child care is the biggest thing"

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[36] *Id.*

[37] Bar-Walker, *supra* note 29, at 13.

[38] Varney, *supra* note 31.

[39] *Id.*

[40] *Id.*

impeding an abortion, because the journey is often "a three-day ordeal."[41]

The ongoing COVID-19 pandemic has further exacerbated these problems, as the obstacles that people face when required to travel long distances to obtain abortions "are made worse by COVID-19 due to unprecedented financial constraints, school and day-care closures, and social distancing guidance."[42] Women who must travel for abortions also often experience unwanted delays in getting abortions because they need time to gather funds for travel costs in addition to their procedure.[43] That delay causes further harm, as the longer an abortion is delayed, the more expensive the procedure becomes.[44] "Abortions in later stages of pregnancy generally start at $1,000 for the procedure and the cost goes up from there."[45]

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[41] *Id.*

[42] *Access to Abortion During the COVID-19 Pandemic and Recession*, National Women's Law Center 2 (Mar. 2021), https://nwlc.org/wp-content/uploads/2021/04/3.21-Brief-1-1.pdf.

[43] Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, 28 J. Women's Health 1623, 1629–30 (2019), https://www.liebertpub.com/doi/pdfplus/10.1089/jwh.2018.7496; Diana Greene Foster & Katrina Kimport, *Who Seeks Abortions at or After 20 Weeks?*, 45 Persp. on Sexual & Reprod. Health 210, 212–15 (2013), https://onlinelibrary.wiley.com/doi/epdf/10.1363/4521013.

[44] Varney, *supra* note 31. Delays in abortions also cause heightened medical risks. *See infra*, Section III.C.

[45] Susan Dunlap, *With a Health Care Crisis Under Way, New Mexico Could Be Critical for Abortion Access*, The NM Political Report (Feb. 6, 2020),

Consider Amber's story from Alabama. When she became pregnant, she knew she "couldn't afford another child," and she "called two clinics and visited another before finding a clinic three hours from her home that could perform her abortion."[46] She then had trouble securing transportation to get to her procedure, and "during this delay, her gestation advanced such that she required a different and more costly procedure, which she struggled to afford."[47] By the time Amber secured the funds to cover her procedure and travel, she was 20 weeks pregnant.[48]

Finally, numerous other circumstances in women's daily lives can increase the financial burden. For those who experience domestic abuse, their abusers may restrict access to money, transportation, and other resources.[49] This may constitute a significant portion of women who are forced to travel out of state to obtain an abortion, as anywhere "[b]etween 6 and 22 percent of women terminate their pregnancies because they are in an abusive relationship."[50]

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https://nmpoliticalreport.com/2019/11/13/accessto-abortion-limited-in-nm/.

[46] Foster & Kimport, *supra* note 43, at 216.

[47] *Id.*

[48] *Id.* at 215–16.

[49] Joan B. Kelly & Michael P. Johnson, *Differentiation Among Types of Intimate Partner Violence: Research Update and Implications for Interventions*, 46 Fam. Ct. Rev. 477, 481 (2008).

[50] LySaundra Campbell, *The Hidden Link Between Domestic Violence and Abortion*, Rewire News Group (Oct. 24, 2019), https://rewirenewsgroup.com/article/2019/10/24/the-hidden-link-between-domestic-violence-and-abortion/.

B. Traveling out of state to obtain abortions has significant psychological effects that should not be overlooked.

In addition to the financial impacts (which already cause severe stress on women seeking abortions), many women also experience psychological harm from making the deeply personal and difficult decision of whether to seek an abortion. Traveling out of state to obtain the procedure can significantly compound that harm.

For example, because many women cannot afford or arrange for travel without assistance, they may be required to disclose their decision to obtain an abortion to others. This can lead to further stigmatization of that choice,[51] particularly in places where abortion is most frowned-upon for religious or cultural reasons. In a report that evaluated 12 qualitative studies of abortion seekers, all but two revealed that "disclosure of having or needing an abortion, often to individuals that participants did not want to tell, were a direct result of the burden posed by needing to travel."[52] Forced disclosure can be traumatic for people who wanted to keep that personal decision private.

Further, many women experience heavy emotional burdens as a direct result of travel, including "feeling uncomfortable and lonely while traveling alone for a procedure, feeling stressed from the need to figure out transportation and other

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[51] Kristen M. Shellenberg et al., *Social Stigma and Disclosure About Induced Abortion: Results from an Exploratory Study*, 6 Global Pub. Health S111, S118–19 (2011).

[52] Bar-Walker, *supra* note 29, at 13.

logistics, as well as feeling stigmatized for the need to travel for routine medical care."[53] One woman who traveled from Alabama to Georgia for her abortion reflected that "[t]he procedure itself was probably the least traumatic part of it" when compared to the ordeal she was forced to endure to get it.[54] She said that if the procedure would have been at her hospital, "there would have been a feeling like what [she] was doing was OK and a reasonable choice."[55]

Stigmatization and emotional trauma can take other forms, too. For example, because some states have mandatory waiting periods before or after women obtain abortions, out-of-state patients who cannot afford lodging "often … sleep[] in their car" while they wait for their appointments, which can be humiliating and demoralizing.[56] Others who seek lodging at nearby hotels may face discrimination there. An employee at Fund Texas Choice, a nonprofit that helps arrange and pay for travel for Texas residents seeking out-of-state abortions, said that there is "a particular hotel in Albuquerque" that "[i]f they found out you were going to the [abortion] clinic, they up-charged [you]," and "[a]t one point, they threw our client out of the hotel. It was horrifying."[57] And women traveling out of state for abortions often do not

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[53] *Id.* at 13–14.

[54] Cassidy, *supra* note 6.

[55] *Id.*

[56] Torey Van Oot, *I'm an Abortion Travel Agent*, Refinery29 (Jan. 30, 2017), https://www.refinery29.com/en-us/2017/01/138436/texas-abortion-travel-agent-stories.

[57] *Id.*

have their friends or family nearby to comfort them during what can be a very difficult time.[58]

Additionally, as a result of COVID-19 physical distancing restrictions, many patients must wait outside the abortion clinic until their appointment time, making them more susceptible to harassment from anti-abortion protesters. According to the Fund Texas Choice employee, "[p]rotestors can actually be more of a logistical obstacle than you might think."[59] She told a story about a client who "fl[ew] all the way out to Albuquerque [from Texas], dr[ove] to the clinic, and f[ound] herself unable to penetrate the crowd. She got so panicked and was so upset that she … missed her appointment."[60]

Women traveling out of state to receive abortions are also often unfamiliar with their surroundings and therefore may be more likely to be persuaded to go to a crisis pregnancy center—facilities that purport to offer comprehensive reproductive health care, including abortions, but instead actively dissuade abortion seekers from getting care.[61] As of 2010, there were more than 200 of these centers in California

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[58] Varney, *supra* note 29.

[59] Van Oot, *supra* note 56.

[60] *Id.*

[61] Joanne D. Rosen, *The Public Health Risks of Crisis Pregnancy Centers*, Guttmacher Institute 201–05 (Sept. 10, 2012), https://www.guttmacher.org/journals/psrh/2012/09/public-health-risks-crisis-pregnancy-centers.

alone.[62] These centers are often purposely located next to abortion providers, increasing the odds that out-of-state patients will be misled and not receive or delay receiving critical care that they need.[63]

Finally, because of the substantial burdens women face when seeking an abortion out of state, fewer will be able to obtain the abortions they want and will thus be forced to live with an unwanted pregnancy as a result.[64] Although most demand for abortions would continue even if the Court were to allow pre-viability prohibitions on abortion, the projected increases in travel distances are expected to deter abortion incidence by nearly 13%.[65] In other words, approximately *120,000 women* per year would be unable to obtain an abortion because they are unable to travel the necessary distance to receive one.[66] This inflicts psychological hardships on both these women and the children born as a result of

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[62] *Unmasking Fake Clinics: The Truth About Crisis Pregnancy Centers in California*, NARAL Pro-Choice California Found., https://www.sfcityattorney.org/wp-content/uploads/2015/08/Unmasking-Fake-Clinics-The-Truth-About-Crisis-Pregnancy-Centers-in-California-.pdf (last visited Sept. 19, 2021).

[63] Amy G. Bryant & Jonas J. Swartz, *Why Crisis Pregnancy Centers Are Legal but Unethical*, 20 AMA J. of Ethics 269, 270–71 (Mar. 2018), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-04/pfor1-1803.pdf.

[64] Myers, *supra* note 22, at 372.

[65] *See id.*

[66] *See id.*

unwanted pregnancies throughout their lives.[67] The Court should not overlook these real, lasting psychological effects that women seeking abortions experience when access to abortions is not readily available.

C. Forcing women to travel out of state to obtain abortions can undermine their medical decision-making abilities and subject them to needless medical risks for otherwise safe procedures.

Because women do not give up on seeking an abortion when providers are unable to offer appointments, they desperately search for other, often riskier options. Indeed, many who travel out of state to obtain abortions will be forced to endure medical risks that would not exist had they been able to obtain an abortion locally.[68]

Specifically, restrictive abortion laws that lead women to travel for abortions can result in delays in care that reduce the efficacy and quality of otherwise

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[67] *Abortion and Mental Health*, Am. Psych. Assoc., https://www.apa.org/pi/women/programs/abortion (last visited Sept. 6, 2021) ("Unwanted pregnancy has been associated with deficits to the subsequent child's cognitive, emotional and social processes.").

[68] As discussed, *supra* in Section II.D, increased travel to out-of-state abortion providers will also impact the timing and quality of abortion care in-state residents will receive if abortion-care resources in their state are constrained by increased demand from out-of-state patients.

safe legal abortions.[69] Studies show that legal abortions in the United States are "safe and effective," with serious complications occurring "far less frequently than during childbirth."[70] But by "limit[ing] the number of available providers, misinform[ing] women of the risks of the procedures …, overrul[ing] their decision making, or requir[ing] medically unnecessary services" and imposing mandatory waiting periods, abortion-restrictive laws "do[] not improve … safety" for women seeking abortions and can "actually worsen" it.[71] Indeed, a 2018 study noted that "delaying" abortion "increases the risk of harm to the woman" because the risk of a serious complication, while still rare, "increases with weeks' gestation" and "[a]s the number of weeks increases, the invasiveness of the required procedure and the need for deeper levels of sedation also increase."[72] For example, "medical abortion," which is only available during the first 10

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[69] *See* Nat'l Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 10–11 (2018), https://doi.org/10.17226/24950.

[70] *See id*. at 11; *see also* Genevra Pittman, *Abortion Safer than Giving Birth: Study*, Reuters (Jan. 23, 2012), https://www.reuters.com/article/us-abortion/abortion-safer-than-giving-birth-study-idUSTRE80M2BS20120123.

[71] *See* Nat'l Academies, *supra* note 69, at 10–11; *see also* Alison Kodjak, *Landmark Report Concludes Abortion in U.S. Is Safe*, NPR (Mar. 16, 2018), https://www.npr.org/sections/health-shots/2018/03/16/593447727/.

[72] Nat'l Academies, *supra* note 69, at 77–78.

weeks of pregnancy and is obtained via pills,[73] may be less risky than abortions performed later in gestation, which while still safe, are more invasive (like suction curettage abortions and dilation and evacuation).[74] Therefore, a woman who would have, but for abortion-restrictive laws or bans, obtained a less-invasive medical abortion from a local care provider, may instead be forced to delay her abortion for out-of-state travel and obtain a riskier one.

Bans limiting abortion access during the COVID-19 pandemic, discussed *supra* in Section II.B, illustrate the delays and increased risks that result when abortion access is restricted but demand remains the same. For example, in May 2020, Texas (which limited abortions during the pandemic), saw an 83% increase in abortions at 12 or more weeks' gestation, a more costly and potentially more medically risky procedure.[75] A survey of independent abortion providers further revealed that in states that declared abortion non-essential, over 70% of clinics canceled or postponed medication abortions, and over 90% canceled or postponed first-trimester

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[73] *See Medical vs. Surgical Abortion*, Whole Woman's Health, https://www.wholewomanshealth.com/medical-vs-surgical-abortion/ (last visited July 14, 2021).

[74] *See Medical Versus Surgical Abortion*, UCLA Health, https://www.uclahealth.org/obgyn/medical-versus-surgical-abortion (last accessed Sept. 2, 2021); *see also* Nat'l Academies, *supra* note 74, at 79–80.

[75] Amy Littlefield, *As the Pandemic Raged, Abortion Access Nearly Flickered Out*, The Nation (Feb. 23, 2021), https://www.thenation.com/article/society/abortion-access-covid-pandemic/.

procedures.[76] Thus, women in these states were forced to delay their care and, as a result, obtain a more medically risky abortion.

Women traveling out of state to obtain abortions may also experience a reduced quality of abortion aftercare. After expending time and resources to travel out of state, many women cannot afford to return to that provider for follow-up appointments. They may instead have to self-treat any after-effects or seek care at an emergency facility. Studies show a correlation between greater distances traveled for an abortion and an increased likelihood of seeking subsequent care at an emergency facility, as well as a "reduced likelihood of seeking subsequent care at the original abortion site."[77] Seeking abortion aftercare services from an emergency facility may also lead to reduced quality of care. "Compared with [emergency facility] staff, abortion providers are typically better equipped to evaluate abortion patients' symptoms and avoid unnecessary use of additional interventions."[78]

Women traveling long distances to obtain abortions may also be stripped of autonomy over their medical decision-making, as abortion restrictions effectively force them to choose termination methods

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[76] Sarah C.M. Roberts, *COVID-19 and Independent Abortion Providers: Findings from a Rapid-Response Survey*, 52 Persp. on Sexual and Reprod. Health 217, 221 (2020).

[77] *See* Ushma Upadhyay et al., *Distance Traveled for an Abortion and Source of Care After Abortion*, 130 Obstetrics & Gynecology 616, 621 (Sept. 2017), https://journals.lww.com/greenjournal/Fulltext/2017/09000/Distance_Traveled_for_an_Abortion_and_Source_of.17.aspx.

[78] *Id*. at 622.

they would not have otherwise chosen. The story of Ana, a 21-year-old woman from Texas, is instructive. Ana first called her local clinic to make an appointment when she was six weeks pregnant but was told that the wait time would be three weeks—"a common occurrence in Texas due to capacity issues created by … clinic shortage."[79] A three-week delay would have pushed Ana outside the time permitted for the *type* of abortion she wanted,[80] and increased the *cost* of her abortion so as to make it "financially out of reach."[81] Rather than wait, Ana made an appointment with a clinic over 300 miles away.[82] But, because Texas law requires follow-up appointments after medical (i.e., pill-based) abortions—which was the termination method Ana preferred—and because Ana could not afford to make the trip again for an additional visit, she had no choice but to undergo a surgical abortion that did not require a follow-up appointment.[83] Ana's story is not unique. Many have had to forgo their preferred, less invasive abortion method in favor of surgical abortion to limit the travel distance, number of visits, and possibility of

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[79] *See* Madeline M. Gomez, *More than Mileage: The Preconditions of Travel and the Real Burdens of H.B. 2*, 33.1 Col. J. of Gender & L., 49, 53–54 (2016).

[80] If Ana sought an abortion in Texas today, under S.B. 8, a three-week delay would preclude her from seeking an abortion entirely.

[81] *Id*.

[82] *Id.*

[83] *See id.*

experiencing abortion symptoms, like cramping and bleeding, while traveling.[84]

Finally, travel-related costs and barriers to abortion may at times be so severe as to lead women to self-induce their abortions, rather than see an abortion provider.[85] A review of studies analyzing women's experiences traveling for abortion found that one-third of the qualitative studies analyzed described travel-related burdens "forc[ing] some participants to consider or attempt self-inducing to end their pregnancies."[86] Selena, for example, is a Texas resident who resorted to self-inducing after her local clinic shut down, leaving the next closest provider four hours away.[87] If the Court decides that pre-viability abortion restrictions are subject to something less than undue-burden review or are otherwise constitutional, it is not only needless medical risks and costs for otherwise safe abortion procedures that will rise. Incidents of women taking matters into their own hands, as Selena did, will also undoubtedly increase.

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[84] *See* Bar-Walker, *supra* note 29, at 14.

[85] *See id*.

[86] *Id*.

[87] *See* Ellen Wulfhorst, *Up Against Strict Laws, Texas Women Learn Do-It-Yourself Abortions*, Reuters (May 24, 2016), https://www.reuters.com/article/us-abortion-usa-texas-doityourself/up-against-strict-laws-texas-women-learn-do-it-yourself-abortions-idUSKCN0YF1BC.

D. Women living in poverty and women of color disproportionately shoulder burdens arising from out-of-state abortions.

Studies show that women living in poverty are more likely both to seek an abortion and live in states with the most restrictive abortion laws.[88] In 2014, 75% of abortion patients in the United States were low-income individuals; nearly 50% lived below the federal poverty level.[89] Of 21 states categorized as hostile or very hostile to abortion,[90] 14 have the highest percentages of total population living in

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[88] Erin Durkin, *'Women Will Die': How New Abortion Bans Will Harm the Most Vulnerable*, The Guardian (May 19, 2019), https://www.theguardian.com/us-news/2019/may/19/abortion-ban-alabama-women-of-color-poor; Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, Guttmacher Institute (June 2017), https://www.guttmacher.org/journals/psrh/2017/04/barriers-abortion-care-and-their-consequences-patients-traveling-services.

[89] Rebecca Wind, *Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates*, Guttmacher Institute (Oct. 19, 2017), https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates.

[90] *See* Elizabeth Nash, *State Abortion Policy Landscape: From Hostile to Supportive*, Guttmacher Institute (Dec. 30, 2020), https://www.guttmacher.org/article/2019/08/state-abortion-policy-landscape-hostile-supportive (defining "hostile" and "very hostile" based on the various categories of abortion restrictions and protections).

poverty among all states.[91] One such state is Mississippi, which is categorized as "very hostile" to abortion rights[92] *and* has the highest percentage of individuals living in poverty among all states—19.5%.[93] For women living in poverty in these restrictive states, the high costs of travel and increased medical burdens discussed *supra* in Sections III.A & C, may make it all but impossible to obtain an abortion.[94] Low-income women living in states with better abortion access will also feel the effects of out-of-state travel, as abortion resources in their home states are constrained by an influx of out-of-state patients seeking an abortion.[95]

For these same reasons, women of color will also unfairly shoulder the costs and burdens associated with out-of-state abortions regardless of where they live. One analysis of Texas SB8 found that

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[91] *See Percent of Total Population in Poverty, 2019*, U.S. Dep't of Agric. (Jan. 5, 2021), https://data.ers.usda.gov/reports.aspx?ID=17826#P5202283d01e847a194b2d55ae25e3a99_2_229iT3.

[92] Nash, *supra* note 90, at 2.

[93] U.S. Dep't of Agric., *supra* note 91.

[94] Shannon Brewer, the director of Respondent, Jackson Women's Health Organization, has noted that "women can barely afford to come [to her facility], much less go out of state." Ariane de Vogue, *Poorest Americans Could See Biggest Impact of Reversing* Roe v. Wade, CNN (July 30, 2021), https://www.cnn.com/2021/07/30/politics/roe-v-wade-abortion-ginsburg-barrett/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+rss%2Fcnn_topstories+%28RSS%3A+CNN+-+Top+Stories%29.

[95] *See supra* Section II.D.

the law would "particularly affect Black patients and those living on low incomes or who live far from" an abortion provider.[96] More broadly, women of color make up the majority of patients who seek abortion services in the United States.[97] Nine states that are considered "hostile" or "very hostile" to abortion have at least 40% of their population identifying as something other than "white alone."[98] And due to "chronic racism" and "deeply entrenched inequities in the areas of health insurance coverage[] [and] health care,"[99] women of color are already more likely to experience "barriers to abortion and other

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[96] Kari White et al., *Texas Senate Bill 8: Medical and Legal Implications*, Texas Policy Evaluation Project (July 2021), http://sites.utexas.edu/txpep/files/2021/07/TxPEP-research-brief-senate-bill-8.pdf.

[97] *See* Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, Guttmacher Institute (Aug. 2008), https://www.guttmacher.org/gpr/2008/08/abortion-and-women-color-bigger-picture.

[98] *See* Nash, *supra* note 90, at 2; *see also Race and Ethnicity in the United States: 2010 Census and 2020 Census*, U.S. Census Bureau (Aug. 12, 2021), https://www.census.gov/library/visualizations/interactive/race-and-ethnicity-in-the-united-state-2010-and-2020-census.html; Jamila Taylor, *Women of Color Will Lose the Most if* Roe v. Wade *Is Overturned*, Ctr. for Am. Progress (Aug. 23, 2018), https://www.americanprogress.org/issues/women/news/2018/08/23/455025/women-color-will-lose-roe-v-wade-overturned/.

[99] Jessica Arons & Medina Agenor, *Separate and Unequal: The Hyde Amendment and Women of* Color, Ctr. For Am. Progress 13–16 (2010), https://cdn.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/hyde_amendment.pdf.

reproductive and maternal health services."[100] Increased burdens imposed by out-of-state travel for abortion will only further exacerbate these inequities.

CONCLUSION

The Court should uphold its precedent and affirm the Fifth Circuit's holding that Mississippi's ban on pre-viability elective abortions is unconstitutional. But if the Court is inclined to revisit its decades of abortion jurisprudence affirming the constitutional right to choose an abortion pre-viability, it should maintain its undue-burden framework and hold that any restrictions that impose an undue burden on women seeking abortions—regardless the stage of pre-viability pregnancy—are unconstitutional. At the very least, the Court should continue considering the significant harm that women forced to travel long distances to obtain abortions will face as a factor when evaluating the constitutionality of any abortion restriction or prohibition. Restrictions that have the effect of requiring women to travel outside their home states to obtain abortions cause significant hardships on both these women and the states that must absorb out-of-state patients. The Court cannot simply overlook these hardships when determining whether an abortion prohibition or restriction is constitutional.

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[100] Taylor, *supra* note 98; *see also* Marcela Howell & Ann M. Starrs, *For Women of Color, Access to Vital Health Services Is Threatened*, Guttmacher Institute (July 27, 2017), https://www.guttmacher.org/article/2017/07/women-color-access-vital-health-services-threatened.

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