No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, *et al.*,

Petitioners,

v.

KIRK COLE, COMMISSIONER, TEXAS DEPARTMENT OF STATE HEALTH SERVICES, *et al.*,

Respondents.

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

BRIEF OF *AMICI CURIAE* NATIONAL NETWORK OF ABORTION FUNDS AND 41 MEMBER ABORTION FUNDS IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*[1]

Amici Curiae the National Network of Abortion Funds ("NNAF") and 41 abortion funds are organizations that work on behalf of low-income individuals and families by providing funds to enable them to afford and access the abortion they seek. This Brief is submitted to provide the Court with factual context as to how the challenged provisions of Texas House Bill No. 2 unduly burden low-income abortion patients by imposing obstacles in the way of obtaining an abortion, including longer waiting times for scheduling an appointment and longer distances to travel to obtain the procedure. Ultimately, the challenged restrictions have the effect of both increasing the cost of an abortion past the point where many can afford it and making the procedure less accessible by increasing the burden of traveling to the reduced number of facilities that perform an abortion. Included herein are descriptions of the costs of abortion procedures, how restrictive legislation affects those costs, how low-income people specifically are affected by the costs, and the struggles they endure to pay for and obtain an abortion. Also included are the accounts of individuals who have suffered harm due to the burdens imposed by abortion-related restrictions that purport to advance women's health but do not actually serve that goal, including the provisions of the Texas statute at issue here.

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1. This Brief is submitted with the written consent of all parties pursuant to Supreme Court Rule 37.3(a). Letters of consent are attached hereto as Exhibit A. Pursuant to Supreme Court Rule 37.6, counsel for *amici* certify that no counsel for any party had any role in authoring this brief in whole or in part, and that no person other than *amici curiae*, their members, or their counsel made any monetary contribution intended to fund the preparation or submission of this Brief.

To assist those seeking an abortion, communities of volunteers have come together to raise funds to cover the costs of the procedure, as well as transportation, hotels for overnight stays, meals, and childcare. The first abortion funds were founded in the late 1960s and early 1970s, before *Roe v. Wade*, to assist patients traveling to states where abortion was legal. Following the Supreme Court's recognition of a constitutional right to abortion, more abortion funds were formed around the country. In 1993, 22 abortion funds in 14 states joined together to form the NNAF.[2]

Amicus NNAF is a network of local abortion funds supporting those who need money for their abortion procedure, as well as for the additional costs of childcare, transportation, lodging, and assistance planning other logistics. A majority of callers served by NNAF and its member funds are living at or below the federal poverty line and have at least one child. In 2014, NNAF and its member funds received 116,000 requests for funds and were able to contribute $3.5 million in funding for nearly 30,000 people. An additional $90,000 was offered to support 1,500 people with transportation, childcare, and lodging costs. Local abortion funds supported an additional 2,400 patients with both financial and logistical support for their abortion.

Despite the efforts of NNAF and other abortion funds, thousands of requests for financial assistance by low-income patients go unanswered. *Amici* have an interest in patients' continued ability to access abortion services, in

2. National Network of Abortion Funds, *Our Story*, *available at* http://www.fundabortionnow.org/about/our-story (last accessed Dec. 29, 2015).

reducing the harm done to patients seeking an abortion, and in maximizing the number of patients NNAF and its member funds can help.

In addition to NNAF, *amici curiae* include the following local and statewide abortion funds:

A Fund, Inc. (Louisville, Kentucky)

Abortion Support Network

Access Reproductive Care-Southeast (ARC-Southeast)

ACCESS Women's Health Justice (California)

Aphrodite Access Fund (Vestal, New York)

Blue Ridge AAF, Inc. (Charlottesville, Virginia)

Carolina Abortion Fund

Central Florida Women's Emergency Fund

Chicago Abortion Fund

Clinic Access Support Network (Houston, Texas)

Eastern Massachusetts Abortion Fund

Emergency Medical Assistance, Inc. (Palm Beach Gardens, Florida)

Frontera Fund (McAllen, Texas)

Fund Texas Choice

Gateway Women's Access Fund (St. Louis, Missouri)

Iowa Abortion Access Fund

Jane Fund of Central Massachusetts

Kentucky Health Justice Network

Lilith Fund for Reproductive Equity (Austin, Texas)

Magnolia Fund (Atlanta, Georgia)

Make A Difference Fund (San Diego, California)

Mississippi Reproductive Freedom Fund

Network for Reproductive Options (Oregon)

New Jersey Abortion Access Fund

New Orleans Abortion Fund, Inc.

New York Abortion Access Fund

North Dakota Women In Need (WIN) Abortion Access Fund

Preterm (Cleveland, Ohio)

Pro-Choice Resources (Minneapolis, Minnesota)

Richmond Reproductive Freedom Project (Richmond, Virginia)

Texas Equal Access Fund

The Abortion Rights of Western Massachusetts

The CAIR Project (Seattle, Washington)

The DC Abortion Fund (Washington, District of Columbia)

The Freedom Fund (Denver, Colorado)

West Fund (El Paso, Texas)

Women for Women (Lander, Wyoming)

Women Have Options (Ohio)

Women's Medical Fund (Philadelphia, Pennsylvania)

Women's Medical Fund, Inc. (Madison, Wisconsin)

Women's Reproductive Rights Assistance Project (Los Angeles, California)

SUMMARY OF THE ARGUMENT

As the Supreme Court held in *Planned Parenthood v. Casey* in considering the constitutionality of abortion

regulations, "[a]n undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability." 505 U.S. 833, 898 (1992). The statutory provisions at issue are designed to impose substantial obstacles in the path of people seeking an abortion, creating an undue burden on their constitutional right to an abortion.

The Supreme Court has long protected a patient's right to obtain an abortion, prohibiting laws that place an undue burden on that right. However, undue burdens arise from far more circumstances than directly restricting the right to obtain an abortion. Restrictions on abortion providers can also impose substantial obstacles for abortion patients. The challenged provisions of the Texas regulations result in the closing of abortion clinics, which increases wait times at the remaining clinics and forces patients to travel farther to obtain an abortion. By imposing such delays on an abortion, the Texas restrictions increase the cost of an abortion because the procedures become more costly later in a pregnancy. Longer waits can also prevent a patient from obtaining an abortion, as some clinics will not perform abortions later in a pregnancy, and Texas prohibits an abortion after 20 weeks gestation. Traveling farther for a procedure increases the time it takes to obtain an abortion, which increases transportation costs, childcare costs, and lost wages.

These burdens fall more heavily on low-income patients. Multiple appointments, longer travel, and higher costs cause greater difficulties for low-income patients who do not have the resources or networks to cope with them. A person with means may be better able to miss a day of

work or schedule childcare than a lower-income person who may have to make difficult choices like missing a day of work and the earnings from it, or leaving a young child with family for two days in order to travel a full day for an abortion.

A disproportionate number of patients seeking an abortion live near the poverty line. Low-income people are especially affected by restrictions on abortion that make it more costly. They are especially unlikely to have insurance that will cover the cost of an abortion. One of the reasons for this is that federal policy and many state laws, including Texas law, prohibit Medicaid coverage of abortion in most circumstances. In addition, lacking sufficient resources to pay for abortion care leads to delays in accessing care, which can in turn drive up costs and create a self-reinforcing cycle.

Moreover, when provider restrictions cause clinic closures, low income individuals face additional and unique burdens imposed by increased delays in obtaining an appointment at a local clinic or the necessity of traveling long distances to access a provider, and those burdens can include adverse health outcomes, threats to their economic security and livelihoods, and negative impacts on their children and families. Low-income patients are often forced to solicit funds from friends, family, and organizations like *amici*. Many are unsuccessful and find themselves forced to carry an unwanted pregnancy to term. Laws like those under consideration here unduly burden their constitutional rights.

In this Brief, in addition to describing the costs of abortion procedures and how restrictions affect

those costs, *amici* share the stories of several women encountering and overcoming the costly obstacles imposed by the unnecessary state law restrictions on abortion providers. The experiences of these patients are emblematic of people seeking abortion across Texas. The practical consequences of these laws are very real to *amici* and the low-income patients they serve.

ARGUMENT

I. THE CHALLENGED PROVISIONS OF H.B. 2 IMPOSE BARRIERS ON PATIENTS SEEKING AN ABORTION

A. H.B. 2 Imposes an Undue Burden On Patients Seeking an Abortion in Texas By Causing A Drastic Reduction In the Number of Open Clinics

On July 18, 2013, Texas enacted House Bill No. 2 ("H.B. 2"),[3] which imposes severe and unduly burdensome restrictions on abortion care. The challenged provisions of H.B. 2 require abortion clinics to meet all of the standards applicable to ambulatory surgical centers ("ASCs") and require abortion-providing physicians to have admitting privileges at a local hospital. These requirements burden low-income women and drive up the costs of abortion in several ways, resulting in more low-income patients who are unable to obtain an abortion at all. As the district court held in this action:

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3. House Bill No. 2 [hereinafter H.B. No. 2], 83rd Leg., 2nd Spec. Sess. (Tex. 2013).

> The act's two requirements erect a particularly high barrier for poor, rural, or disadvantaged women throughout Texas, regardless of the absolute distance they may have to travel to obtain an abortion. A woman with means, the freedom and ability to travel, and the desire to obtain an abortion, will always be able to obtain one, in Texas or elsewhere. However, Roe's essential holding guarantees to all women, not just those of means, the right to a previability abortion.[4]

The requirement that abortion clinics meet the building standards of ASCs imposes unnecessary and expensive upgrades that most clinics will not be able to meet, forcing many clinics to close their doors.[5] Prior to the enactment of H.B. 2 Texas had 41 licensed facilities that provided abortion services on a regular basis. As of June 12, 2015, that number has fallen to 19.[6] If the Court upholds the ASC requirement only ten or fewer clinics will remain open.[7]

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4. *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 683 (W.D. Tex. 2014).

5. Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, Guttmacher Policy Review, Spring 2013, Vol. 16, No. 2, available at https://www.guttmacher.org/pubs/gpr/16/2/gpr160207.html (last accessed Dec. 27, 2015).

6. Letter from Stephanie Toti to Lyle W. Cayce at 1, *Whole Woman's Health v. Cole*, No. 14-50928 (5th Cir. June 12, 2015), Document No. 00513077018.

7. *Id.* at 4.

H.B. 2's requirement that abortion care providers have admitting privileges at a hospital within 30 miles of the abortion facility took effect on October 31, 2013. Since then, many providers have been denied admitting privileges, and their clinics have been forced to close.[8] According to data from the Texas Policy Evaluation Project,[9] in the several months following the ASC provision taking effect, half of Texas abortion facilities closed in large part due to the inability of providers to obtain admitting privileges.[10] Accordingly, the number of women of reproductive age living in Texas who live more than 200 miles from an abortion facility increased from 10,000 in May 2013 to 290,000 by April 2014.[11] During the period when the ASC requirement was in effect, that number increased to 750,000.[12]

The closure of facilities can have a dramatic effect on the practical cost of an abortion. Fewer clinics means

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8. Texas Policy Evaluation Project, *Fact Sheet*, Aug. 13, 2015, at 2, *available at* https://utexas.box.com/shared/static/kvesz96nv0rc8jqii45c9kvxuls6f7lh.pdf (last accessed Dec. 29, 2015).

9. The Texas Policy Evaluation Project is a five-year comprehensive effort to assess the impact of reproductive health measures passed by the 82nd and 83rd Texas Legislatures. The project includes researchers at the University of Texas Population Research Center, the University of California at San Francisco, Ibis Reproductive Health, and the University of Alabama-Birmingham.

10. Texas Policy Evaluation Project, *Access to abortion care in the wake of HB2*, July 1, 2014, *available at* http://www.utexas.edu/cola/txpep/_files/pdf/AbortionAccessafterHB2.pdf (last accessed Dec. 29, 2015) [hereinafter *Access to abortion care*].

11. *Id.*

12. Texas Policy Evaluation Project, *Fact Sheet*, *supra* note 8, at 2.

that the remaining facilities are busier and waiting times for appointments are longer.[13] An abortion performed later in a pregnancy is more expensive.[14] In addition, the declining number of facilities forces women to travel farther, take more time off work, and employ childcare for longer periods.[15]

Patients who are unable to afford to travel to an abortion clinic may even attempt to self-induce an abortion. Women interviewed by the Texas Policy Evaluation Project reported that the closing of a local clinic, the cost of travel, the cost of the procedure, the stigma of seeking an abortion, or some combination of these factors led them to attempt to self-induce an abortion. The common thread among those reporting an attempt to self-induce an abortion is poverty.[16]

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13. Texas Policy Evaluation Project, *Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*, Oct. 5, 2015, available at https://utexas.box.com/shared/static/4ne8joivir5q019u4pkds73odcadzw12.pdf (last accessed Dec. 29, 2015) [hereinafter *Abortion Wait Times*].

14. Jenna Jerman & Rachel K. Jones, *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, Women's Health Issues, 24-4, 2014, at e419, *available at* http://www.guttmacher.org/pubs/journals/j.whi.2014.05.002.pdf (last accessed Dec. 29, 2015) [hereinafter *Secondary Measures*].

15. Rachel K. Jones, et al., *At What Cost? Payment for Abortion Care by U.S. Women*, Women's Health Issues, 23-3, 2013, at e174, *available at* https://www.guttmacher.org/pubs/journals/j.whi.2013.03.001.pdf (last accessed Dec. 29, 2015) [hereinafter *At What Cost*].

16. Texas Policy Evaluation Project, *At Least 100,000 Texas Women Have Attempted Abortion Self-Induction*, Nov. 17, 2015, *available at* http://www.utexas.edu/cola/txpep/index.php (last accessed, Dec. 29, 2015).

For this Brief, *amicus* NNAF interviewed several abortion patients who struggled with the burdens imposed on their right to obtain an abortion.[17] Tiffany's story is representative of what many abortion patients face in Texas. For Tiffany, saving money to afford an abortion led to a delay in scheduling a procedure. Clinic closures caused scheduling congestion, which resulted in additional delays. The delays resulted in an increased cost of the procedure that she was already struggling to afford. To obtain an abortion she had to miss work, lose wages, and cut back on basic expenditures.

Tiffany is a 30 year-old woman from Flint, Texas who had an abortion in mid-October 2015. After Tiffany became aware of her pregnancy at 11 weeks gestation, she obtained an estimate of the cost of an abortion and learned that she would need time to save money to afford the procedure because she was uninsured. After she saved $300, she sought to schedule an appointment in Dallas, encountering another delay in obtaining an appointment due to congestion at the clinic. By the time Tiffany had raised $300 and obtained an appointment in Dallas, she had reached 18 weeks gestation and the cost of the abortion had risen to $1,700, well beyond the sum she could afford or raise. In addition to the cost of the procedure, Tiffany also struggled to afford the cost of transportation to Dallas, three hours roundtrip, plus an overnight hotel stay.

17. Recordings and transcripts of interviews with the women whose accounts are presented here are on file with the NNAF. One of the names of the patients who contributed their story has been changed; all others are referred to only by their first name and hometown.

To save money for the procedure and logistical costs, Tiffany cut expenses wherever possible. She limited her own meals, often only to soup. Tiffany left her young daughter in the care of her mother so that her mother would pay for her daughter's meals allowing Tiffany to save additional funds for her abortion. When she left for Dallas for two days to have the abortion, she left her daughter with her mother, but could not tell her mother where she was going. With all of the obstacles that Tiffany faced, up until the moment she was on the road, she was justifiably afraid that something would happen to stop her from obtaining an abortion.

Had Tiffany not been able to obtain funding from the Texas Equal Access Fund for the abortion and hotel, and costs of travel to and from the clinic, she would not have been able to obtain an abortion. She reports that since she works paycheck to paycheck without insurance, paying for the procedure was hard, but it would have been harder not to have the abortion. She believes that having the baby would have left her worse off, possibly forcing her onto public assistance. Said Tiffany,

> I just feel like what's the point of having to have a child that's gonna [sic] be always in the system of always having food stamps, Medicaid, all this government help.… It's not easy to just have a kid and not have the money to support them. I think that if I would have went [sic] through with it, I think that I wouldn't have been good off [sic]. I would have been asking for a lot of help.

Her story is typical. Tiffany's finances delayed her abortion by the time it took to raise funds to pay for it. H.B. 2 caused clinics to close, which exacerbated waiting times, forcing Tiffany to delay her abortion further. Transportation and hotel costs increased her burdens. She lost an estimated $160 for missing two days of work. She was able to avoid the cost of childcare only by leaving her daughter with her mother.

B. H.B. 2 Imposes Delays, Logistical Problems With Jobs and Childcare, Substantial Costs, and In Some Cases an Inability To Obtain an Abortion At All

The delays and increased travel distances caused by the challenged restrictions of H.B. 2 increase the burdens on low-income patients seeking an abortion. Encountering delays in scheduling an abortion can be fear-inducing experience for someone already having difficulty paying for the procedure or arranging for time off of work or childcare. Traveling farther may mean missing more time at work, which creates job instability, especially for lower-income patients living paycheck to paycheck. Having to obtain childcare more than once or leaving work for multiple appointments may result in a loss of privacy through an unwanted disclosure of a pregnancy or an abortion.

Clinic closures have the effect of increasing congestion at the remaining clinics and forcing women to travel farther for care. The Texas Policy Evaluation Project found that after the recent clinic closings wait times for an abortion appointment increased to as many as 20 days in several metropolitan areas, thereby pushing many

people seeking abortion into their second trimester.[18] This delay is in addition to the preexisting delays in obtaining an abortion. In a 2004 study, of patients who sought a first-trimester abortion but obtained a second-trimester abortion, 38 percent cited delays in scheduling an appointment or inability to find a local clinic as the reason for the delay.[19]

Delays can also eliminate the ability to access a local clinic. There are more facilities willing or able to perform an abortion at earlier gestational times. "In 2009, 95% of facilities offered abortion services at 8 weeks' gestation, but only 23% did so at 20 weeks, and 11% at 24 weeks. During this same year, an estimated 4000 women were unable to obtain abortion because they were past facilities' gestational limits by the time they made it there."[20]

C. Delays Increase the Cost Of an Abortion

Delays resulting from clinic closures raise the cost of abortion procedures as well as the ancillary costs associated with getting to the procedure, missing work, arranging for childcare, etc. For low-income patients, the delays from clinic closures are layered on top of the delays

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18. Texas Policy Evaluation Project, *Research Brief, Abortion Wait Times in Texas: The Shrinking Capacity of Facilities and the Potential Impact of Closing Non-ASC Clinics*, Oct. 5, 2015, at 2, *available at* https://utexas.app.box.com/AbortionWaitTimeBrief (last accessed Dec. 29, 2015).

19. Lawrence B. Finer, et al., *Timing of steps and reasons for delays in obtaining abortions in the United States*, CONTRACEPTION 74 (2006) 334, at 335, *available at* https://www.guttmacher.org/pubs/2006/10/17/Contraception74-4-334_Finer.pdf (last accessed, December 29, 2015).

20. Jerman & Jones, *Secondary Measures, supra* note 14, at e420 (citations omitted).

they already suffer as a result of needing time to scrape together funds to pay for the procedure.

The delays in obtaining care, whether as a result of clinic closures or the time needed to save to cover the cost of an abortion, often result in a more costly procedure, because the cost of an abortion increases with gestational duration.[21] For example, Tiffany suffered a delay of several weeks that increased the cost of her abortion from $300 at 11 weeks gestation to $1,700 at 18 weeks. Part of the delay for Tiffany was simply the time it took her to raise money to pay for the procedure.

A 1984 "study based on in-depth interviews in a clinic found that Medicaid-eligible patients who were delayed by the time taken to acquire money for an abortion procedure were delayed by 2–3 weeks, and some were delayed into the second trimester."[22] Not only do delays into the second-trimester increase the cost of the abortion because second-trimester procedures are more expensive, but the delays also increase the ancillary costs associated with the procedure. Some second-trimester procedures require multiple visits to the provider (for medical rather than legislative reasons), which in turn increases transportation costs, and may increase childcare costs and lost wages.[23]

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21. Michele Gilman, *A Court for the One Percent: How the Supreme Court Contributes to Economic Inequality*, 2014 Utah L. Rev. 389, 407 (2014)

22. Stanley K. Henshaw, et al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, Guttmacher Institute, June 2009, at 28, *available at* https://www.guttmacher.org/pubs/MedicaidLitReview.pdf (last accessed Dec. 29, 2015) [hereinafter *Restrictions on Medicaid Funding*]; Texas Policy Evaluation Project, *Abortion Wait Times*, *supra* note 18.

23. Jones, et al., *At What Cost*, *supra* note 15, at e174.

Delays caused by fewer clinics can result in the loss of an ability to obtain an abortion, especially for low-income patients. One in four women on Medicaid are forced to carry an unwanted pregnancy to term because they cannot afford to pay the prohibitive cost of an abortion out of pocket and federal and state laws restricts the use of public money for abortion coverage.[24]

Gwen, 31 years old, from Fort Worth, Texas sought an abortion after she was raped by her fiancé. After the assault, Gwen suffered from depression and lost a lot of weight. By the time she found out she was 12 weeks pregnant, Gwen weighed 87 pounds and had two epileptic seizures. She decided to seek an abortion, however she was unable to go to a clinic in Fort Worth due to her health condition and was sent to a clinic in San Antonio. Gwen says the original abortion would have cost $700, but after the delays the cost increased to $1,300 plus the cost of gas for her car and an overnight stay in a San Antonio hotel. She was unable to save the money in time and take enough time off of work to have her abortion and, as of the time of her interview by NNAF, has been unable to obtain a safe abortion. Of her pregnancy resulting from her rape, Gwen says, "I didn't know if I was capable of loving that baby. Regardless it's my baby and it's something I have to get past."

24. Henshaw, et al., *Restrictions on Medicaid Funding*, *supra* note 22, at 27.

II. THE BARRIERS IMPOSED BY H.B. 2 WILL FALL MOST HEAVILY ON LOW INCOME WOMEN SEEKING ABORTION SERVICES IN TEXAS

A. Cost Is a Significant Barrier To Abortion Access

The cost of, and ability to access, an abortion varies widely across the United States, as does the profile of those seeking an abortion.[25] According to the Guttmacher Institute,[26] one in three women will have an abortion by the age of 45 in the United States.[27] Of these women, 61 percent are already parenting at least one child; over 30 percent are parenting two or more children.[28]

Those who have an abortion report that financial concerns weigh heavily in their decision. Three quarters of women having an abortion cite as reasons "concern for or responsibility to other individuals;" being unable to afford a child; or "that having a baby would interfere

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25. Rachel K. Jones, Lawrence B. Finer, and Susheela Singh, *Characteristics of U.S. Abortion Patients, 2008*, Guttmacher Institute, 2010, *available at* http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf (last accessed Dec. 29, 2015)).

26. The Guttmacher Institute advances sexual and reproductive health and rights worldwide through an interrelated program of research, policy analysis and public education. It regularly conducts original research and publishes reports on these topics.

27. Guttmacher Institute, *Fact Sheet, Induced Abortion in the United States*, July 2014, *available at* http://www.guttmacher.org/pubs/fb_induced_abortion.html (last accessed Dec. 29, 2015) [hereinafter *Fact Sheet, Induced Abortion*].

28. *Id.*

with work, school or the ability to care for dependents."[29] This is not surprising considering the disproportionate representation of low-income women among those who decide to end a pregnancy. Of women having an abortion, 42 percent have incomes below the federal poverty level, while an additional 27 percent have incomes that fall between 100 and 199 percent of the federal poverty level.[30]

For low-income patients, the cost of an abortion can be an extraordinary burden. For context, the poverty guidelines issued by the Department of Health and Human Services identify the poverty line as beginning at $11,770 for a one-person household, adding $4,160 for each additional person in the household.[31] A single woman earning 100 percent of the poverty line earns $980.83 per month. An average first-trimester abortion, without any ancillary costs, would consume nearly half a month of earnings. The average second-trimester abortion would consume a month and a half of earnings or more. Adding costs of travel, lodging, childcare and lost earnings, an abortion can easily consume a large percentage of the patient's earnings.

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29. *Id.* (citing Lawrence B. Finer, et al., *Reasons U.S. women have abortions: quantitative and qualitative perspectives*, Perspectives on Sexual and Reproductive Health, 2005 37(3):110–118, *available at* https://www.guttmacher.org/pubs/journals/3711005.pdf (last accessed Dec. 29, 2015)).

30. Guttmacher Institute, *Fact Sheet, Induced Abortion*, *supra* note 27; Jones, Finer, & Singh, *Characteristics of U.S. Abortion Patients, 2008*, *supra* note 25.

31. Annual Update of the HHS Poverty Guidelines, 80 Fed. Reg. 3236 (Jan. 22, 2015).

Courtney, a 31-year old uninsured woman living in La Marque, Texas, who was interviewed for this Brief, noted the impact of the lack of abortion and economic instability on mothers who already had children in her community. She struggles financially with the three children she is already raising. Courtney said that "[s]ometimes you don't know where your next meal is going to come from or how you're going to pay this bill or [how you're going to save money] to make sure they eat." She stated that she would rather have an abortion "than bring another kid into the world and make them suffer."

For many low-income patients, the cost of an abortion is a significant burden on a household budget that is already stretched to the breaking point. For example, Courtney had trouble coming up with the funds for her abortion and her travel to a clinic in Houston, about an hour away from her home. For her $490 abortion, Courtney borrowed $300 from a friend, used $40 that she saves for gas every week, and obtained the rest from an abortion fund. She is paying her friend back as soon as she can by delaying payments for electric utilities.

B. The Barriers Imposed By H.B. 2 Will Fall Most Heavily On Low-Income Women

The cost of an abortion varies based on location, procedure, and gestational duration, but on average costs have been fairly stable over time.[32] In 2009, a first-

32. Magda Schaler-Haynes, et al., *Abortion Coverage and Health Reform: Restrictions and Options for Exchange-Based Insurance Markets*, 15 U. Pa. J.L. & Soc. Change 323, 330 (2012) ("The cost of a first trimester abortion has stayed constant--even decreased in some cities--for three decades, despite considerable

trimester medical abortion cost an average of $490, and a first-trimester surgical abortion cost an average of $451.[33] Costs increase later in a pregnancy, as medical abortion becomes unavailable and surgical procedures become more complicated.[34] The average cost of a second-trimester abortion in 2009 was $1500.[35] A 2011–2012 study by the same author found the median cost of $500 for an abortion at 10 weeks gestation, and $1350 for an abortion at 20 weeks gestation.[36] In addition, ultrasound requirements (whether medically necessary or not) increase the cost of the abortion procedure by an average of $264.[37]

The cost of the procedure is not the only cost of an abortion. Many patients also incur ancillary costs of gas, travel, lodging, lost wages, and childcare.[38] In a study in the American Journal of Public Health, researchers asked

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medical inflation.") (citing Gina Kolata, *As Abortion Rate Decreases, Clinics Compete for Patients*, N.Y. Times, Dec. 30, 2000.

33. *Id.*; Jerman & Jones, *Secondary Measures, supra* note 14, at e419. "Most abortion clinics try to keep prices for surgical and medical abortions at comparable rates to avoid creating financial incentives for clients to choose one method over another." *Id.*

34. *Id.* ("Abortions performed in hospitals are considerably more expensive.") (citing Stanley Henshaw, *Factors Hindering Access to Abortion Services*, 27 Family Planning Persp. 54, 58 (1995)).

35. *Id.*; Jones, et al., *At What Cost*, *supra* note 15, at e174; Jerman & Jones, *Secondary Measures, supra* note 14, at e419.

36. Jerman & Jones, *Secondary Measures*, *supra* note 14, at e419.

37. Healthcare Bluebook, *Abdominal Ultrasound*, *available at* https://healthcarebluebook.com/page_ProcedureDetails.aspx?id=162&dataset=MD (last accessed Dec. 29, 2015).

38. Jones, et al., *At What Cost*, *supra* note 15, at e174.

women seeking abortion at 30 different clinics in the U.S. what prevented them from going to a clinic earlier in their pregnancy; "[c]osts and travel involved were the top reason the women gave."[39] A 2010–11 study found that of women paying out-of-pocket for an abortion, two-thirds reported an average of $44 in transportation costs.[40] Six percent reported an average of $140 for hotel costs.[41]

More than one quarter of respondents in the 2010–11 study reported an average of $198 in lost wages.[42] Many of the women interviewed for this Brief suffered from unpaid absences from work. Tiffany was forced to take two days off for her procedure, losing $160 in earnings. Courtney missed five hours of work to travel to and from her and attend appointment an hour and a half away, losing $85 in earnings. LaPorcha, a 27-year old in Fort Worth, Texas, who works at a call center lost more than $160 in earnings.

For some the fear of losing a job rivals the burden of lost wages. Tiffany, who works at a medical center, discovered her pregnancy a few weeks before starting a new job. Because of delays, she had to miss work during the orientation period at her new job and present a note from the abortion clinic as proof for her absence, a disclosure she would not have had to make had she been able to schedule her procedure sooner, before starting her new job.

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39. Olga Khazan, *Waiting Periods and the Rising Price of Abortion*, The Atlantic (May 26, 2015), *available at* http://www.theatlantic.com/health/archive/2015/05/waiting-periods-and-the-price-of-abortion/393962/ (last accessed Dec. 29, 2015).

40. Jones, et al., *At What Cost*, *supra* note 15, at e176.

41. *Id.*

42. *Id.*

One tenth of respondents in the 2010–11 survey reported spending an average of $57 for childcare.[43] But the cost of childcare is not the only difficulty facing a low-income parent seeking an abortion. The logistics of childcare can be daunting, as can the fear of not being able to obtain the abortion and trying to take care of another child on an already stretched budget. Two-thirds of women having an abortion are already parenting at least one child.[44] Abortion patients sometimes turn to family members and friends for support; however, many low-income patients don't have people in their networks who are able to provide that assistance, and many state that they feel uncomfortable telling their family and friends they are seeking an abortion.

Courtney, a mother of three children, scheduled her first appointment during the school day while her children were in preschool and grade school. For her second appointment, Courtney was able to leave her children with her sister, but she hid the fact that she was having an abortion from her sister. LaPorcha, also a mother of three, had her first appointment while her children were in school, however her second appointment spanned time while the children were not in school and she had to rely on her sister for childcare.

Of women paying out-of-pocket for an abortion, 52 percent said that it was difficult to pay for the procedure. This is not surprising as "[m]ost women obtaining

43. *Id.*

44. Finer, et al., *supra* note 29.

abortions were poor or low income."[45] Fifty-nine percent indicated they obtained some money from friends, family or organizations.[46] Patients who rely on others to help pay for an abortion, often need hundreds of dollars to bridge the gap between what they can afford and the cost.[47] This money sometimes comes from a provider discount, where the abortion clinic lowers the cost of the procedure for individual patients, though that rarely covers the entire cost of the procedure.[48] A small percentage of patients borrow money from friends or family. This group is small because low-income families tend not to have disposable income at the ready or generational wealth that would allow for the lending of their financial resources.[49] A substantial safety net is provided by organizations like *amici*, which take private donations and channel them to abortion fund hotline callers who lack sufficient resources to pay for their abortion procedure or the ancillary costs of travel, lodging, or other logistics.[50] The closure of abortion clinics significantly increases the need for additional funds by patients.

As stated previously, NNAF received 116,000 requests for abortion funding assistance in 2014, but could only fulfill just under 30,000 requests. While NNAF and its member funds attempt to cover the gap in abortion

45. Jones, et al., *At What Cost*, *supra* note 15, at e174.

46. *Id.* at e175.

47. *Id.* at e177.

48. Jones, Finer & Singh, *supra* note 25, at 11.

49. *Id.* at 11.

50. Schaler-Hanes, et al., *supra* note 32, at 336.

funding, they are often unable to cover other costs such as childcare, travel, and overnight hotel stays. With more abortion restrictions, like those in H.B. 2, the need will continue to grow and the assistance provided by organizations like *amici* will never be able to keep pace.

Without the funds to pay for an abortion, nearly 60 percent of women on Medicaid who seek abortion care are forced to pay for the abortion out of set-aside savings that would otherwise have covered daily necessities such as food, clothing, and childcare.[51] Some patients have had to pawn their possessions to raise the money to pay for an abortion.[52] Importantly, the arduous process of raising money to pay for an abortion delays the patient's ability to have the abortion, which in turn increases the costs of the procedure.

Some patients simply cannot afford to pay for an abortion. "Three studies found that between eighteen and thirty-seven percent of pregnancies that would have been terminated if funding had been available through the state's Medicaid program, were instead carried to term."[53] Carrying an unintended pregnancy to term can

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51. American Civil Liberties Union, *Public Funding for Abortion*, *available at* https://www.aclu.org/public-funding-abortion (last accessed Dec. 29, 2015).

52. Heather D. Boonstra and Adam Sonfield, *Rights Without Access: Revisiting Public Funding of Abortion for Poor Women*, The Guttmacher Report on Public Policy, Vol. 3, No. 2 (April 2000), *available at* http://www.guttmacher.org/pubs/tgr/03/2/gr030208.html (last accessed Dec. 29, 2015).

53. Schaler-Hanes, et al., *supra* note 32, at 337 (citing James Trussell, et al., *The Impact of Restricting Medicaid Financing for Abortion*, 12 Fam. Planning Persp. 120, 129 (1980); M. Chrissman, et al., *Effects of Restricting Federal Funds for Abortion--Texas*, 29

have negative results. Abortion patients know what is best for them. Indeed, a study from the University of California San Francisco found that women who were unable to obtain the abortion they sought were three times as likely to live in poverty two years later.[54]

C. The Challenged Provisions of H.B. 2 Combine With Other Restrictions that Burden Low-Income Women

In addition to the challenged provisions of H.B. 2, Texas also requires the use of an outdated protocol for the administration of medical abortion (also known as medication abortion), one that increases the number of clinic appointments required to obtain a medical abortion from one to at least three.[55] Also not challenged herein, a requirement to have an ultrasound 24-hours prior to the procedure may increase the number of appointments to four. Combined with the delays and increased travel

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Morbidity & Mortality Wkly. Rep. 253, 253 (1980); and S. Philip Morgan & Allan M. Parnell, *Effects on Pregnancy Outcomes of Changes in the North Carolina State Abortion Fund*, 21 Population Res. & Pol'y Rev. 319, 322 (2002)).

54. Joshua Lang, *What Happens to Women Who Are Denied Abortions?*, The New York Times Magazine, June 12, 2013, available at http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?_r=0 (last accessed December 27, 2015). More information on the Turnaway Study being conducted at the University of California San Francisco's Bixby Center for Global Reproductive Health can be found at http://www.ansirh.org/research/turnaway.php.

55. Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers – and Threaten U.S. Trend Toward Very Early Abortion*, Guttmacher Policy Review (Winter 2013), *available at* http://www.guttmacher.org/pubs/gpr/16/1/gpr160118.html (last accessed Dec. 29, 2015).

times associated with clinic closures due to the admitting privileges and ASC requirements, these restrictions turn a simple doctor's appointment into a series of hurdles and indignities including repeatedly missing work, losing wages, and arranging for childcare.

Also not challenged herein, Texas bans abortion after 20 weeks of pregnancy post-fertilization, even in cases of rape.[56] Since the challenged provisions of H.B. 2 will result in delays in obtaining an abortion because of clinic closures, the 20-week ban means that some of those delays will result in patients being prohibited from obtaining an abortion at all. This restriction also will detrimentally impact a disproportionate number of patients with limited resources and chronic illnesses. People most likely to obtain second-trimester abortions are adolescents aged 18 and 19, individuals with less education, and people who experienced multiple disruptive life events within the year of their pregnancy.[57]

CONCLUSION

The ability to access an abortion is central to a person's ability to become financially stable and provide for the children they already care for and love. The patients interviewed for this Brief sought an abortion because they believed it the best decision for their own and their families' lives, so that they could better care for

56. H.B. 2, Sec. 171.044.

57. Rachel K. Jones & Lawrence B. Finer, *Who has second-trimester abortions in the United States?*, Guttmacher Institute, Dec. 16, 2011, at 11–12, *available at* http://www.guttmacher.org/pubs/journals/j.contraception.2011.10.012.pdf (last accessed Dec. 29, 2015).

the children they have, and avoid the financial catastrophe that can flow from an unwanted pregnancy.

State legislation like H.B. 2 imposes undue burdens in accessing abortion. Those burdens fall hardest on low-income patients who struggle to afford an abortion procedure and to overcome the obstacles in the path of their obtaining an abortion. Many of the patients interviewed for this Brief cited the economic harm to them and their families that would result if they could not obtain an abortion. When the state tips the scales against them, their constitutional right becomes unattainable and meaningless. If the constitutional right to an abortion described in *Roe v. Wade* and *Planned Parenthood v. Casey* is to have any meaning, restrictions like those contained in HB 2 must be recognized as the unconstitutional undue burdens that so many low-income people seeking abortion experience them to be.

At a Duke University School of Law event in July of 2015, Justice Ruth Bader Ginsburg noted that abortion, whether it remained legal or not, would always be accessible to those who could afford it. To the audience, she noted:

> There's a sorry situation in the United States, which is essentially that poor women don't have choice. Women of means do. They will, always. Let's assume *Roe v. Wade* were overruled and we were going back to each state for itself, well, any woman who could travel from her home state to a state that provides access to abortion, and those states never go back to old ways … So if you can afford a plane ticket, a train ticket

> or even a bus ticket you can control your own destiny but if you're locked into your native state then maybe you can't. That we have one law for women of means and another for poor women is not a satisfactory situation.[58]

Sadly, Justice Ginsburg is correct. If the states can continue to ratchet up costs for abortion providers and women, then the constitutional protection of a patient's right to an abortion is hollow and meaningless, especially for low-income patients.

Wherefore, a*mici* respectfully request that the Court reverse the decision below.

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58. Samantha Lachman, *Ruth Bader Ginsburg Calls "Choice" An Empty Concept For Poor Women*, Huffington Post, July 20, 2015, *available at* http://www.huffingtonpost.com/entry/ruth-bader-ginsburg-reproductive-rights_55ba42c9e4b095423d0e0716 (last accessed December 29, 2015).