Nos. 23-235 and 23-236

In the Supreme Court of the United States

U.S. FOOD AND DRUG ADMINISTRATION, ET. AL.,
Petitioners,
v.
ALLIANCE FOR HIPPOCRATIC MEDICINE, ET AL.,
Respondents.

DANCO LABORATORIES, L.L.C., *Petitioner,*
v.
ALLIANCE FOR HIPPOCRATIC MEDICINE, ET AL.,
Respondents.

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

BRIEF OF *AMICUS CURIAE* NAACP LEGAL DEFENSE & EDUCATIONAL FUND, INC., IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

The NAACP Legal Defense & Educational Fund, Inc. (LDF) is the nation's first and foremost civil rights law organization. Through litigation, advocacy, public education, and outreach, LDF strives to secure equal justice under the law for all Americans and to break down barriers that prevent Black people from realizing their basic civil and human rights.

For decades, LDF has pursued litigation to secure the economic rights of Black families and individuals. Litigation to ensure the adequacy of health care and hospital services available to Black communities has been a long-standing LDF concern. *See, e.g., Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980) (challenging the closing of Sydenham public hospital in Harlem under Title VI of the Civil Rights Act of 1964).

Black women and Black pregnant people face profound inequities in accessing essential health care, including abortion care, as a result of the legacy and persistence of anti-Black racism. LDF has supported efforts to promote equal rights and access to reproductive health care, emphasizing the impact of restrictions on abortion access on Black women[2]

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amicus curiae* state that no counsel for a party authored this brief in whole or in part and that no person other than *amicus curiae*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief. *Amicus curiae* provided all parties timely notice of their intention to file this brief.

[2] *Amicus curiae*'s use of "woman" or "women" is not meant to exclude transgender men and nonbinary people that may be able to become pregnant and need to seek abortion services.

and other pregnant people living in poverty. *See, e.g.*, *Rust v. Sullivan*, 500 U.S. 173 (1991); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Whole Woman's Health v. Jackson*, 595 U.S. 30 (2021); *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022).

LDF has an interest in this case, which will decide whether the U.S. Food and Drug Administration ("FDA") must return to pre-2016 labeling and restrictions on mifepristone, one of the drugs used in a common and safe two-drug medication abortion protocol. Limitations on medication abortion will limit the health care options available to Black and low-income people. Consistent with its efforts to secure equal access to health care, LDF has a strong interest in ensuring continued access to safe abortion care.

INTRODUCTION AND SUMMARY OF ARGUMENT

More than twenty years ago, the FDA approved the drug mifepristone as safe and effective for the medical termination of pregnancy as part of a two-drug protocol. In 2016 and 2021 the FDA acted reasonably to make modifications to mifepristone's label and Risk Evaluation and Mitigation Strategy ("REMS")[3] based on an exhaustive review of scientific

[3] REMS is a drug safety program that the FDA can require for certain medications. U.S. Food & Drug Admin., *Risk Evaluation and Mitigation Strategies | REMS* (May 16, 2023), https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems. Mifepristone and

evidence before it. Given the severe consequences of both undermining precedent and restricting access to medication abortion, LDF raises two arguments in support of Petitioners.

First, if affirmed, the Fifth Circuit's opinion will impede access to medication abortion, a safe and effective form of abortion care. In so doing, it would arbitrarily limit abortion access in states that have chosen not to restrict abortion care, thereby undermining state policy choices that should be respected.

Second, if the Fifth Circuit's decision is allowed to stand, the suspension of the FDA's 2016 and 2021 actions will exacerbate the impact of inequities in access to health care. Inequitable access to health care disproportionately harms Black women and Black pregnant people who have historically faced, and continue to face, barriers to care due to structural and interpersonal racism.

For these reasons, we respectfully urge this Court to reverse the Fifth Circuit's decision.

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the generic drug Mifeprex are available under the REMS for abortion care. U.S. Food & Drug Admin., *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Mar. 23, 2023), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation.

ARGUMENT

I. The Fifth Circuit's Opinion Will Arbitrarily Restrict Access to Mifepristone in States that Have Made a Policy Decision to Protect Abortion Access.

For over twenty years, mifepristone has been used safely and effectively to terminate early pregnancies for millions of patients as part of a two-drug regimen for medication abortion.

At issue here are challenges to the FDA's actions regarding mifepristone in 2016 and 2021. In 2016, the FDA approved several changes to mifepristone's conditions of use and modified the REMS, including to allow non-physician health care providers licensed to prescribe medications to become certified prescribers of mifepristone.[4] In 2021, after a thorough scientific review, the FDA announced that it would modify the mifepristone REMS to eliminate the in-person dispensing requirements; this followed the FDA's exercise of enforcement discretion regarding the in-person dispensing requirements earlier that year.[5] The FDA exercised its scientific judgment to conclude that the available evidence demonstrated that mifepristone would remain safe and effective with removal of the in-person dispensing requirement.[6] As the FDA correctly argues, the Fifth Circuit did not conclude that the use of mifepristone was unsafe as a result of these changes. Rather, it determined that the FDA did not

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[4] Br. for Fed. Pet'rs at 5.

[5] *Id.* at 6–7.

[6] *Id.* at 44.

"adequately explain its 2016 and 2021 actions," a conclusion that, even if true, does not justify the Fifth Circuit's remedy.[7]

The Fifth Circuit's order to stay the FDA's 2016 and 2021 actions reverts access to mifepristone to the pre-2016 regime. This would place large barriers on accessing medication abortion, including limiting the health care providers who can prescribe the drug.[8] It would also override the FDA's removal of the in-person disbursement requirement, which ensures pregnant women and other pregnant people are afforded greater safety, privacy, and autonomy. Removal of the unnecessary in-person disbursement requirement is especially important because many pregnant women and other pregnant people now rely upon telehealth and the ability to access mifepristone outside of brick-and-mortar abortion clinics.[9]

The Fifth Circuit, in making this decision, improperly second-guessed the FDA's expert judgment about the safety of mifepristone's conditions of use, incorrectly raising the deferential arbitrary and capricious standard to overrule the FDA's actions, when those actions were lawful and clearly within the "zone of reasonableness." *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

Absent intervention from this Court, access to mifepristone will be severely restricted, even in

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[7] *Id*. at 48.

[8] C.A. Add. at 703–04, 791–93.

[9] *See* Society for Family Planning, *#WeCount Report April 2022 to June 2023* (Oct. 24, 2023) (discussing that facilities have added telehealth services and the growth of virtual clinics as a possible explanation for more cumulative abortions from July 2022 to June 2023), https://societyfp.org/wp-content/uploads/2023/10/WeCountReport_10.16.23.pdf.

states that have sought to safeguard abortion access. In the wake of *Dobbs*, many states and the District of Columbia have made policy choices to allow abortion care. Indeed, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, have in recent years expanded legal protections for abortion.[10] Notably, voters in Kansas and Ohio rejected ballot measures restricting abortion access.[11] Access to medication abortion is important in these locations: medication abortion involving mifepristone is estimated to account for more than half of the abortions in the United States,[12] and mifepristone is safely and commonly used as part of the two-drug medication abortion protocol.

State policy choices to maintain and expand abortion access have economic benefits: women in states with better reproductive health care face less occupational segregation, increased job mobility, and increased access to non-wage benefits such as paid

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[10] The N.Y. Times, *Tracking Abortion Bans Across the Country* (last updated Jan. 8, 2024), https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html.

[11] *Id.*

[12] Rachel K. Jones et al., *Medication Abortion Now Accounts for More than Half All US Abortions*, Guttmacher Inst. (Feb. 24, 2022), https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions.

sick days and leave, as well as promotional opportunities.[13]

The benefits of better access to reproductive health care are significant for Black women. For example, Black women are likely to see a seven-percent increase in employment opportunities if they live in places where abortion access is protected.[14] Additionally, abortion access may alleviate labor market problems faced disproportionately by Black women.[15] Black Americans are more likely than white Americans to be living in poverty for the third generation in a row.[16] Because many people who have abortions are already parents, limiting access to abortion care causes increased financial burdens on Black families which can contribute to the racial wealth gap.[17]

The Fifth Circuit's decision, if allowed to stand, would impose significant restrictions on access to mifepristone in contravention of the demonstrated record of safety and efficacy under the FDA's current regime. Further, should the Fifth Circuit's decision stand, there will be additional economic

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[13] *See* Kate Bahnetal, *Linking Reproductive Health Care Access to Labor Market Opportunities for Women*, Ctr. for Am. Progress (Nov. 21, 2017), https://www.americanprogress.org/issues/women/reports/2017/11/21/442653/linking-reproductive-health-care-access-labor-market-opportunities-women.

[14] Kaylee Kaestle, *The Economic Implications of Abortion Bans*, Colorado Fiscal Inst. (June 24, 2022), https://www.coloradofiscal.org/the-economic-implications-of-abortion-bans/issues/economic-prosperity/.

[15] *Id*.

[16] *Id*.

[17] *Id*.

consequences for Black pregnant women and other pregnant people.

II. Staying the FDA's 2016 and 2021 Actions Will Further Impede Equitable Access to Health Care.

By staying the FDA's 2016 and 2021 actions, the Fifth Circuit's decision makes abortion care less available and compounds the problems of racial disparities in access to health care. This decision is also contrary to the extensive evidence considered by the FDA as part of the administrative record, which includes consideration of equitable access to health care. Black pregnant people and other indigent people of color face significant, sometimes insurmountable, obstacles to accessing abortion care even in states that have protected abortion access. If affirmed, the Fifth Circuit's decision will likely exacerbate existing racial disparities in access to equitable, quality, and comprehensive health care driven by economic injustice and systemic racism.

A. The FDA's Administrative Record Reflects that Equitable Access to Safe and Effective Health Care Is an Important Public Health Consideration.

The FDA's changes to the mifepristone label and REMS in 2016 and 2021 were supported by an exhaustive review of the administrative record. Indeed, the Fifth Circuit did not conclude that the FDA ignored any study in the administrative record.[18] In addition to dozens of scientific studies

[18] Br. for Fed. Pet'rs, at 37.

documenting the safe use of mifepristone, the administrative record also includes studies considering the equitable impact of unnecessary abortion restrictions.

One example of the evidence in the administrative record is a literature review from the National Academies of Sciences, Engineering and Medicine in 2018. The committee conducting the study agreed on two fundamental principles: (1) "women should expect that the abortion care they receive meets well-established clinical standards for objectivity" and (2) "the quality of abortion care should be assessed using six dimensions of health care quality," which includes equity.[19] The report defined equity as "providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status."[20] Among its many findings about abortion safety, the report also concluded that abortion restrictions affect pregnant people differently based on their socioeconomic status, disproportionately harming pregnant people who have low incomes.[21]

Similarly, the World Health Organization's ("WHO") technical and policy guidance on safe abortion recommends that "equitable access to good-quality care" is an essential component of national

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[19] Nat'l Acads. of Scis., Eng'g & Med., *The Safety & Quality of Abortion Care in the United States* 3 (2018), https://www.ncbi.nlm.nih.gov/books/NBK507236/.

[20] *Id*. at 3.

[21] *Id*. at 13.

standards and guidelines for safe abortion care.[22] The WHO report recognizes that ethnic minorities and those living in poverty may be vulnerable to inequitable access to safe abortion services, especially where they are unable to pay and services are not covered by insurance.[23] Finally, the report explains how legal restrictions on abortion access leads many pregnant people to travel further for abortion services, "which is costly, delays access and creates social inequities."[24]

In sum, equitable access to safe and effective medications, like mifepristone, is integral to analysis of public health. The FDA's 2016 and 2021 actions removed unnecessary restrictions and altered the

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[22] World Health Org., *Safe Abortion: Technical and Policy Guidance for Health Systems* 8 (2012), https://www.ncbi.nlm.nih.gov/books/NBK138196/.

[23] *Id*. at 68, 80. Other studies in the administrative record further emphasize the connection between the United States' systemic racism and inequality, and lack of insurance coverage for abortion. *See, e.g*., Guttmacher Inst., *Medicaid Coverage of Abortion* (Feb. 2021) ("As a result of the United States's systemic racism and inequality, people of color are more likely to be low income and enrolled in Medicaid—and thus subject to the Hyde Amendment's cruel restrictions. Low-income women and women of color—groups that already experience elevated risk of unintended pregnancy—may be especially affected by the lack of abortion coverage and the substantial cost of a procedure without it.), https://www.guttmacher.org/node/27915/printable/print.

[24] World Health Org., *supra* note 22, at 93. The negative consequences of travel distance on equitable abortion access are documented in other studies in the administrative record. *See, e.g.,* James D. Shelton et al., *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persp. 260–62 (1976) (finding distance is especially disadvantageous to Black pregnant people seeking abortion care), https://pubmed.ncbi.nlm.nih.gov/1001409/.

indications for use of mifepristone to reflect the best evidence and scientific research. These actions, which make a safe and effective medication more accessible, also further equity by removing barriers to medication abortion services. That these actions are not only medically safe but also further equitable access to mifepristone is another reason to give deference to the FDA, as an agency with expertise in public health. *See FDA v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 579 (2021) (Roberts, C.J., concurring in grant of application for stay) (citation omitted) ("[C]ourts owe significant deference to the politically accountable entities with the 'background, competence, and expertise to assess public health.'"). By substituting its judgment for the FDA's expertise, the Fifth Circuit's decision threatens equitable access to health care.

B. Inequities in Access to Abortion Care Further Amplify Existing Racial Disparities in Access to Comprehensive Health Care

Restricting access to mifepristone will make abortion care less available and add to the challenges Black people already face in accessing equitable, quality, and comprehensive health care because of interpersonal and structural racism. Black people face increased barriers to accessing and utilizing

health care,[25] including health insurance coverage,[26] and report experiencing discrimination while seeking or receiving care.[27] Black women are three times more likely to die from an issue related to pregnancy than white women, due to multiple factors, including

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[25] Samuel L. Dickman et al., *Trends in Health Care Use Among Black and White Persons in the US, 1963-2019*, 5 JAMA Network Open e2217383 (Jun. 14, 2022) ("The persistence of large racial gaps in the amounts of medical care delivered to White and Black patients in the US suggests that structural racism is ingrained in the health care system."), https:/doi.org/10.1001/jamanetworkopen.2022.17383; César Caraballo et al., *Trends in Racial and Ethnic Disparities in Barriers to Timely Medical Care Among Adults in the US, 1999 to 2018*, 3 JAMA Network Open e223856 (Oct. 28, 2022) (finding that "worsening racial and ethnic disparities in barriers to timely medical care not directly related to cost of care over 20 years" and that the "overall prevalence of these barriers increased during the 20-year period, but at disparate rates across the 4 race and ethnicity groups studied" with "Black and Hispanic/Latino individuals [] more likely to report experiencing these barriers" when compared to white individuals), https://doi.org/10.1001/jamahealthforum.2022.3856.

[26] Ruqaiijah Yearby, Brietta Clark, & José F. Figueroa, *Structural Racism In Historical And Modern US Health Care Policy*, 41 Health Aff. 187, 189–191 (Feb. 2022), https://doi.org/10.1377/hlthaff.2021.01466.

[27] A study conducted in 2020 found that participants cited race and ethnicity as the top factors in unfair treatment when accessing medical care with 10.6% of Black adults stating that they faced discrimination while seeking care based on their race, sexual orientation, disability, gender or health condition, compared to 3.6% of white adults and 4.5% of Latino adults. Nicquel T. Ellis, *Black adults report bias in health care at higher rates than White and Latino people, study finds*, CNN (Apr. 6, 2021), https://www.cnn.com/2021/04/06/health/black-adults-health-care-discrimination/index.html.

structural racism and implicit bias.[28] Curtailing access to medication abortion will likely amplify existing racial disparities in health for Black pregnant people.[29]

Structural barriers to receiving health care reflect historical segregation and the under-resourcing of predominantly Black communities. In 1946, Congress passed the Hospital Survey and Construction Act ("Hill–Burton Act"), which provided grants to states for hospital construction and allowed for segregated facilities so long as there was "equitable distribution of hospital beds for each population group."[30] Although the number of hospital beds increased as a result of the Hill-Burton Act, a 1956 study found that in the South only six percent of hospitals offered Black people services without restrictions, and thirty-one percent did not admit Black people under any conditions, even in an

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[28] Ctrs. for Disease Control & Prevention, *Working Together to Reduce Black Maternal Mortality* (Apr. 3, 2023), https://www.cdc.gov/healthequity/features/maternal-mortality/index.html.

[29] Samantha Artiga, *What are the Implications of the Overturning of Roe v. Wade for Racial Disparities?*, KFF (Jul. 15, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities/.

[30] Title VI, Pub. L. No. 79-725, § 622(f) (1946); *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 Md. L. Rev. 316 (1979) https://digitalcommons.law.umaryland.edu/mlr/vol39/iss2/5/; P. Preston Reynolds, *Professional and Hospital Discrimination and the US Court of Appeals Fourth Circuit 1956–1967*, 94 Am. J. Pub. Health 710, 710 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448322/; Yearby et al., *supra* note 26.

emergency.[31] While passage of the Civil Rights Act of 1964 coupled with fiscal incentivization through Medicare brought an end to de jure segregation, de facto segregation in hospitals remains.[32] For example, in a 2023 report examining racial inclusivity in hospitals, "some of the most and least racially inclusive hospitals are concentrated in the same metro areas, reflecting segregation in the healthcare market," and "many of the cities with segregated hospital markets also have large gaps in life expectancy by race."[33] Additionally, there is a high correlation between the legacy of residential racial segregation and higher rates of health disparities in formerly redlined areas.[34]

While the creation of Medicaid and Medicare initially helped reduce the Black-white mortality gap,[35] the discretion granted to states in funding and creating eligibility requirements has disproportionately impacted Black people and other marginalized groups in qualifying for Medicaid

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[31] Reynolds, *supra* note 30, at 711.

[32] Denisse R. Marquez & Hazel Lever, *A Call for Health Care Desegregation*, 25 AMA J. of Ethics 3, 3 (2023), https://journalofethics.ama-assn.org/sites/joedb/files/2022-12/fred1-2301.pdf.

[33] Lown Inst., *Hospital Racial Inclusivity*, https://lownhospitalsindex.org/americas-most-racially-inclusive-hospitals-2023/#methodology.

[34] Zinzi D. Bailey et al., *How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities*, 384 N. Engl. J. Med. 768, 768–769 (2021), https://www.nejm.org/doi/pdf/10.1056/NEJMms2025396?articleTools=true.

[35] Dorothy Roberts, *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century* 144–146 (2011).

coverage.[36] Research suggests that state adoption of Medicaid expansion decreases significantly when the percentage of the Black population in the state increases.[37] Several states in the South have the highest percentage of Black people and uninsured Black adults.[38] As of 2022, some of those same states in the South have chosen not to expand Medicaid.[39]

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[36] Yearby et al., *supra* note 26.

[37] Jane Perkins & Sarah Somers, *The Ongoing Racial Paradox of the Medicaid Program*, 16 J. Health & Life Sci. 96, 102 (May 2022) ("Meanwhile, the failure to expand hurts millions of low-income people, a large proportion of whom are Black, Latino, or other people of color. Today, echoing the original holdouts from adopting Medicaid, 12 states still refuse to expand their Medicaid programs. The percentage of the population that is Black in these states are Mississippi 38%, Georgia 31%, Alabama 27%, South Carolina 26%, North Carolina 21%, Tennessee 16%, Florida 15%, Texas 12%, Kansas 6%, Wisconsin 6%, South Dakota 2 %, and Wyoming 1%. Seven of these states have populations of Black people higher than the national rate of 13%. Texas also has the highest proportion of Hispanic residents of any state (40%), while South Dakota has the third highest proportion of Native Americans (8%)."), https://healthlaw.org/wp-content/uploads/2022/05/The-Ongoing-Racial-Paradox-of-the-Medicaid-Program.pdf.

[38] Assistant Sec'y for Plan. & Evacuation's Off. of Health Pol'y, *Health Insurance Coverage and Access to Care Among Black Americans: Recent Trends and Key Challenges* 5 (Feb. 22, 2022) ("Alabama, Florida, Georgia, and Mississippi are the states with both the highest percentage of Black Americans and the highest uninsured rates among Black adults in 2019. Notably, Alabama, Florida, Georgia, and Mississippi have not expanded Medicaid eligibility to low-income adults with incomes up to 138 percent of the Federal Poverty Level (FPL), as of February 2022."), https://aspe.hhs.gov/sites/default/files/documents/08307d793263d5069fdd6504385e22f8/black-americans-coverages-access-ib.pdf.

[39] *Id*.

Thirteen percent of Black women aged fifteen to forty-nine have no health insurance compared to eight percent of white women.[40] Black women of reproductive age face the biggest disparity in insurance coverage.[41] Further, because the Hyde Amendment prohibits federal funding of most abortions, and many states restrict private insurers from covering abortion services, most people will need to come up with the out of pocket costs associated with medication abortion care.[42] Based on a recent report, the median patient costs for medication abortion was $568.[43] This does not account for the other associated costs such as travel, lost wages, and childcare expenses.[44] Women of color are less likely to have enough cash on hand to cover an emergency expense,

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[40] Liza Fuentes, *Inequity in US Abortion Rights and Access: The End of Roe Is Deepening Existing Divides*, Guttmacher Inst., (Jan. 17, 2023), https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides.

[41] Nat'l Partnership for Women & Families, *Fact Sheet: Black Women Experience Pervasive Disparities in Access to Health Insurance* (2019), https://www.nationalpartnership.org/our-work/resources/health-care/black-womens-health-insurance-coverage.pdf.

[42] Ushma Upadhyay et al., *Trends in Self-Pay Charges And Insurance Acceptance for Abortion in The United States, 2017–20*, 41 Health Affairs 507 (Apr. 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01528.

[43] Advancing New Standards in Reproductive Health, *Trends in Abortion Care in the United States, 2017–2021* (June 2022), https://www.ansirh.org/sites/default/files/2022-06/Trends%20in%20Abortion%20Care%20in%20the%20United%20States%2C%202017-2021.pdf.

[44] Upadhyay et al., *supra* note 42.

like abortion care.[45] Studies demonstrate that the out of pocket costs for abortion care coupled with travel expenses pose significant barriers to accessing abortion care.[46]

Lack of insurance access or restrictions on using insurance for services cause many pregnant Black women and other pregnant people seeking abortion care to pay out of pocket, potentially forcing them to forego payment of bills and other necessary expenses in order to afford abortion care.[47] Even with the relative progress made to address uninsured rates nationally, as a result of the Affordable Care Act, disparities in access to health care, including access to medication abortion care, remain for Black people.[48]

Racial health disparities also persist, in part, due to the bias Black people, and especially Black women, face when accessing health care. For example, in a 2020 survey, one in five Black adults reported personally experiencing race-based discrimination when receiving health care.[49] Black women were twenty-five percent more likely to report

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[45] Artiga, *supra* note 29.

[46] Advancing New Standards in Reproductive Health, *supra* note 43.

[47] *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, e217 (2014), https://doi.org/10.1016/j.whi.2014.01.003.

[48] Assistant Sec'y for Plan. & Evacuation's Off. of Health Pol'y, *supra* note 39.

[49] Liz Hamel et al., *Race, Health, and COVID-19: The Views and Experiences of Black Americans* 4, KFF (Oct. 2020), https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf.

being treated unfairly when receiving care, and nearly thirty-seven percent of Black mothers shared that they had been treated unfairly while receiving health care or getting care for a family member.[50] A review of studies on health care professionals' interactions with people of color found that:

> [H]ealth care providers' implicit racial bias is associated with diagnostic uncertainty and, for Black patients, negative ratings of their clinical interactions, less patient-centeredness, poor provider communication, undertreatment of pain, views of Black patients as less medically adherent than White patients, and other ill effects.[51]

Racial biases in health care can have a detrimental impact on Black pregnant people's health outcomes. For example, research demonstrates that anti-Black racial biases specifically in pain perception, are associated with biased pain treatment and management, which result in negative maternal health outcomes for Black birthing people.[52] And regardless of their social or economic status, Black women are more

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[50] *Id*. at 27.

[51] Janice A. Sabin, *Tackling Implicit Bias in Health Care*, 387 N. Engl. J. Med. 105, 105 (2022), https://www.nejm.org/doi/pdf/10.1056/NEJMp2201180?articleTools=true.

[52] Nia Josiah et al., *Implicit bias, neuroscience and reproductive health amid increasing maternal mortality rates among Black birthing women*, 10 Nursing Open 5780 (June 16 2023), https://doi.org/10.1002/nop2.1759.

likely to die of pregnancy-related causes than white women.[53]

When Black pregnant women who wish to terminate a pregnancy are unable to access abortion care, including via medication abortion, and remain pregnant, they are at greater risk for adverse health outcomes as demonstrated by racial disparities in maternal health care and the maternal mortality rate.[54] Restricting access to medication abortion exacerbates racial disparities in health and likely results in additional barriers to care that will be disproportionately borne by Black people.

CONCLUSION

This Court should reverse the Fifth Circuit's decision.

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[53] Jamila K. Taylor, *Structural Racism and Maternal Health Among Black Women*, 48 Am. Soc. L. Med. & Ethics 506 (Sept. 2020), https://doi.org/10.1177/1073110520958875.

[54] Artiga, *supra* note 29.

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