No. 26 MAP 2021

IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

Allegheny Reproductive Health Center, et al.,

Appellants,

v.

Pennsylvania Department of Human Services, et al.,

Appellees.

On Appeal from the order of the Commonwealth Court of Pennsylvania, entered March 26, 2021, at No. 26 M.D. 2019.

BRIEF OF THE NATIONAL WOMEN'S LAW CENTER AS *AMICUS CURIAE* SUPPORTING APPELLANTS

Alison Tanner
Michelle Banker
Heather Shumaker
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle NW, Suite 800
Washington, DC 20036
(202) 577-5180
atanner@nwlc.org

Jim Davy
PA ID# 321631
ALL RISE TRIAL & APPELLATE
P.O. Box 15216
Philadelphia, PA 19125
(609) 273-5008
jimdavy@allriselaw.org

Counsel for Amicus Curiae

October 13, 2021

TABLE OF CONTENTS

Page(s)

TABLE OF CITATIONS

Cases **Page(s)**

TABLE OF AUTHORITIES—continued

Page(s)

Codes and Statutes

Constitutions

Other Authorities

TABLE OF AUTHORITIES—continued

Page(s)

TABLE OF AUTHORITIES—continued

Page(s)

TABLE OF AUTHORITIES—continued

Page(s)

TABLE OF AUTHORITIES—continued

Page(s)

TABLE OF AUTHORITIES—continued

Page(s)

INTERESTS OF THE AMICUS CURIAE

The National Women's Law Center is a nonprofit legal advocacy organization founded in 1972 dedicated to the advancement and protection of the legal rights and opportunities of women, girls, and all who face sex discrimination. The Center focuses on issues including economic security, workplace justice, education, health, and reproductive rights, with particular focus on the needs of those who face multiple and intersecting forms of discrimination. Because the ability to decide whether to bear children is of tremendous significance to gender equality and the lives of women and all who can become pregnant, the Center seeks to ensure access and the legal right to abortion and has participated as *amicus* in numerous courts to help protect access and secure this right.

NWLC submits this brief pursuant to Pa.R.A.P. 531(b)(2), and does not repeat arguments made by the parties. Neither party's counsel authored this brief, or any part of it. Neither party's counsel contributed money to fund any part of the preparation or filing of this brief. The brief was prepared entirely by NWLC.

SUMMARY OF ARGUMENT

To deny standing to the Appellants, the Commonwealth Court made a seriously flawed assumption: It concluded that "[t]here is no

obstacle to [Appellants'] patients initiating litigation on their own behalf." This statement could not be further from the truth.

Rather, as a plurality of the United States Supreme Court recognized nearly fifty years ago, "genuine obstacles" prevent abortion patients from asserting their rights in court. *Singleton v. Wulff*, 428 U.S. 106, 117–18 (1976) (plurality op.). In this case, these obstacles include that a patient would have to forgo their right to privacy, risking stigmatization, harassment, and the threat of violence—even if they were permitted to proceed using a pseudonym. Additionally, even if the patient wished to make that difficult decision, they would then be forced to devote their limited resources to litigation instead of using those same resources to overcome the myriad other obstacles to accessing abortion care during the narrow window in which they would have standing to sue.

For these reasons, the Commonwealth Court was wrong as a matter of law that abortion providers lack standing to assert the rights of their patients. NWLC urges this Court to reckon with the reality of the genuine obstacles that all too often prevent abortion patients from advancing their rights in court—obstacles that are heightened for those in need of Medical Assistance. We ask this Court to reverse the decision below and to allow the Appellants to proceed on their patients' behalf.

ARGUMENT

I. The inevitable public disclosure of a patient's abortion decision in court proceedings is a genuine obstacle to patients' ability to litigate.

When it comes to decisions about accessing medical care, especially abortion, privacy is of utmost importance to many people, and this interest would prevent them from seeking to participate in litigation. As a threshold matter, most people are concerned about the confidentiality of their medical and health information and want it to remain private.[1] The protection of that privacy is a core value in the provision of health care.[2] This principle is recognized in federal law, which "gives you rights over your health information and sets rules and limits on who can look at and receive your health information." YOUR RIGHTS UNDER HIPAA, U.S. DEP'T. OF HEALTH & HUM. SERVS., https://bit.ly/3oC7nkd (last visited Oct. 7, 2021).

For many people, those concerns are heightened for abortion care. Some fear disclosing their abortion due to the stigma against abortion, which may inspire negative reactions—ranging from shaming, to

---

[1] A 2005 survey showed that 67% of respondents were concerned about the privacy of their personal health information; for racial and ethnic minority respondents, that fear was even more pronounced, with 73% of respondents expressing concern. *See* LYNN "SAM" BISHOP, ET AL., CAL. HEALTHCARE FOUND., EXECUTIVE SUMMARY: NATIONAL CONSUMER HEALTH PRIVACY SURVEY 2005 1 (2005), https://bit.ly/3BoYQVs.

[2] *See, e.g.*, AM. MED. ASS'N., CODE OF MED. ETHICS: PRIVACY, CONFIDENTIALITY, & MED. RECORDS, https://bit.ly/2Yq4mbS (last visited Oct. 9, 2021) (detailing the importance of privacy and confidentiality in the AMA medical code of ethics).

harassment, to violence—from friends and family, and even from strangers. As such, countless courts have recognized that abortion can be an intensely private matter. *See, e.g.*, *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 766 (1986); *Valley Hosp. Assoc., Inc. v. Mat-su Coal. for Choice*, 948 P.2d 963, 968 (Alaska 1997); *Women of State of Minn. By Doe v. Gomez*, 542 N.W.2d 17, 27 (Minn. 1995). As the U.S. Supreme Court has recognized, a "woman and her physician will necessarily be more reluctant to choose an abortion if there exists a possibility that her decision and her identity will become known publicly." *Thornburgh*, 476 U.S. at 766.

But, as this Court well knows, a legal challenge would necessarily require a patient to reveal their abortion publicly—and thereby submit their decision to public scrutiny. This is so even if the Court might permit the patient to proceed by pseudonym. The Pennsylvania Constitution requires public court proceedings. *See* PA. CONST. art. 1, § 11. And so, the patient would still be required to recount their private medical decision in public court filings. Further, as discussed *infra*, other litigants or their counsel may still learn the patient's identity, and their name may well be made known to the public notwithstanding efforts to keep it anonymous. As a result, an abortion patient will likely "be chilled from" asserting their constitutional rights in order "to protect the very privacy of her decision from the publicity of a court suit." *Singleton*, 428 U.S. at 117 (plurality op.).

a. Abortion stigma may discourage patients from pursuing litigation.

Stigma operates as a powerful deterrent to filing a lawsuit. *See, e.g.*, *Pennsylvania Psychiatric Soc'y v. Green Spring Health Servs., Inc.*, 280 F.3d 278, 290 (3d Cir. 2002). And most people considering abortion perceive some stigma related to their decision. *See* M. ANTONIA BIGG, ET AL., PERCEIVED ABORTION STIGMA AND PSYCHOLOGICAL WELL-BEING OVER FIVE YEARS AFTER RECEIVING OR BEING DENIED AN ABORTION 2 (Whitney S. Rice ed., PLOS ONE 2020).

Stigma can dissuade patients from even speaking openly to their friends and family about abortion care—let alone filing a high-profile lawsuit about their need to access it. Even though the overwhelming majority of patients believe they made the right decision for themselves and their families and are better off because they had an abortion,[3] many patients believe others will see their decision as socially unacceptable, evil, or not normal. *See* Franz Hanschmidt, et al., *Abortion Stigma: A Systematic Review*, 48 PERSPS. ON SEXUAL & REPRO. HEALTH 169, 171–73 (2016). And many patients expect overt discrimination if their decision is made known. *Id.* According to one study, two-thirds of women who had abortions believed that others would look down on them if they knew about it, and 58% felt that they could not tell their family and friends.

[3] *See generally* ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, THE TURNAWAY STUDY (2020), https://bit.ly/3BoOlRL.

See Kristen M. Shellenberg & Amy O. Tsui, *Correlates of Perceived and Internalized Stigma Among Abortion Patients in the USA: An Exploration by Race and Hispanic Ethnicity*, 118 INT'L J. GYNECOLOGY & OBSTETRICS S152, S153–54 (2012). These fears are not unfounded; one abortion patient explained to the U.S. Supreme Court in a recent case that when she informed friends and family of her decision, her father called her a "whore and a monster," and others called her a murderer and told her she was going to hell. These reactions led her to fall into a depression due to feelings of shame. *See* Brief of Amici Curiae Holly Alvarado, et al. at 14, *June Medical Servs. L.L.C. v. Russo*, 140 S. Ct. 2103 (2020). Indeed, perceived abortion stigma can have long-term implications: one study found that high perceived abortion stigma was associated with higher odds of experiencing psychological distress years later. *See* Bigg, *supra*, at 2.[4]

b. Patients often face harassment based on their decision to terminate their pregnancy.

Those who publicly admit to having had an abortion often face harassment. A recent study of people who publicly disclosed their personal abortion stories revealed that 60% experienced online or in-person harassment thereafter. *See* Katie Woodruff, et al., *Experiences of*

[4] Laws like the one at issue here exacerbate the stigma surrounding abortion care; women who live in regions that enact more legislative hurdles to abortion perceive higher levels of abortion stigma. *See* Shellenberg & Tsui, *supra*, at S154.

Harassment and Empowerment After Sharing Personal Abortion Stories Publicly, 2 CONTRACEPTION: X 1, 3 (2020), https://bit.ly/2ZVPXoe. These experiences included threats of physical and sexual assault, including threats of death. *Id.* Fourteen percent reported feeling that they or their loved ones were in physical danger, and 47% reported mental or emotional stress, damage to their reputation, or other negative consequences due to sharing their story publicly. *Id.* at 3–4.

Patients in Pennsylvania are likely well aware that they will experience abortion-related harassment if they share their decision publicly because many experience harassment by anti-abortion extremists from the moment they arrive at the abortion clinic. For example, prior to the passage of a Harrisburg buffer-zone ordinance, anti-abortion extremists were documented harassing patients and staff at abortion clinics by following them from the sidewalk to the clinic door; screaming at them, insulting them, and calling them murderers; taking their pictures and writing down license plate numbers to insinuate threats of future harm; trespassing onto clinic property to bang on windows or take photos inside the clinic; and blocking the clinic driveaway to impede cars from entering. *See Reilly v. City of Harrisburg*, 336 F. Supp. 3d 451, 466 (M.D. Pa. 2018).

Anti-abortion extremists use patients' fear of having their decisions disclosed as a harassment tactic. In one case, after obtaining the names of two women scheduled for abortion care, extremists stood in the clinic's

parking lot on the day of their appointments, holding signs displaying the patients' names. *See Doe v. Mills*, 536 N.W.2d 824, 834 (Mich. Ct. App. 1995). In another, an extremist made harassing phone calls to a patient and her parents and left anti-abortion literature and a plastic model of a fetus at the patient's home. *See Robbinsdale Clinic v. Pro-Life Action Ministries*, 515 N.W.2d 88, 90, 94–95 (Minn. Ct. App. 1994) (Lansing, J., dissenting). In yet another instance, an extremist took photographs of patients in a clinic parking lot and arranged for those photos to be placed on a website designed to deter people from having abortions. *See, e.g.,* Youchi Dreazen, *Abortion Protesters Use Cameras, Raise New Legal Issues, Lawsuits,* WALL STREET J. (May 28, 2002), https://on.wsj.com/3iG693G.

c. Patients may experience violence based on their decision to terminate their pregnancy.

Too often, abortion-related stigma and harassment has led to violence. Since 1993, at least 11 people have been killed in attacks by anti-abortion extremists. *See* NAT'L ABORTION FED'N, 2019 VIOLENCE AND DISRUPTION STATISTICS 8–10 (2019). Acts of violence at abortion clinics have been on the rise for the past several years; violent incidents—including trespassing, vandalism, arson, and assault—more than tripled between 2016 and 2019. *Id.* at 8. In Pittsburgh, a buffer-zone ordinance was passed in response to "bomb threats, vandalism, and blockades of [the] entrance" that abortion clinics in the city faced, in addition to

"aggressive pushing, shoving, and harassing behavior that included shoving literature into people's pockets, hitting them with signs and blocking their entrance into the building" that escalated when budget restrictions forced the police to restrict their presence near the clinic. *Bruni v. City of Pittsburgh*, 941 F.3d 73, 78 (3d Cir. 2019) (internal citations and ellipsis omitted).

This violence has been so pervasive and severe that the United States Congress was prompted to criminalize intimidation of providers and patients and interference with the provision of health care via the Freedom of Access to Clinic Entrances Act, 18 U.S.C. § 248. Likewise, sixteen states, the District of Columbia, and numerous localities have taken action to protect abortion providers and patients from violence and harassment and to ensure access to clinics. *See e.g.,* Harrisburg, Pa. Mun. Code § 3-371 (2015); Pittsburgh, Pa. Mun. Code § 623.01-623.07 (2005); *see also* GUTTMACHER INSTITUTE, PROTECTING ACCESS TO CLINICS (2021), https://bit.ly/3Byl7zS (last visited Oct. 7, 2021). Regular enforcement of these laws continues to be necessary in Pennsylvania and its neighboring states. *See Allentown Women's Center, Inc. v. Sulpizio*, 403 F. Supp. 3d 461, 464 (E.D. Pa. 2019) (describing a protestor who regularly shouts "racial, homophobic, [and] transphobic slurs" outside a Pennsylvania abortion clinic); *see also Havens v. James*, 435 F. Supp. 3d 494, 501–02 (W.D.N.Y. 2020) (describing recent attempts to defy a buffer-zone order that has been enforced around a Rochester abortion clinic for more than

20 years); *New York by Underwood v. Griepp*, No. 17-CV-3706, 2018 WL 3518527, at *23 (E.D.N.Y. July 20, 2018) (describing pervasive harassment at a Queens abortion clinic, including filming patients as they enter the clinic whilst shouting, "You're…killing your child.").

Additionally, patients risk violence in their personal lives if their abortion decisions are revealed. In a survey conducted at two Planned Parenthood clinics in Philadelphia, 21% of patients seeking abortion care reported experiencing intimate partner violence. *See* Rebekah E. Gee, et al., *Power over Parity: Intimate Partner Violence and Issues of Fertility Control*, 201 AM. J. OBSTETRICS & GYNECOLOGY 148.e1, 148.e3 tbl. 1 (2009). If a patient in an abusive relationship has their abortion decision revealed, they may suffer violence at the hands of their partner. *See Viramontes v. Brannon*, 817 Fed. Appx. 243, 245–46 (7th Cir. 2020) (describing murder committed after husband learned of his wife's abortion); Carly O'Connor-Terry, et al., *Challenges of Seeking Reproductive Health Care in People Experiencing Intimate Partner Violence*, J. INTERPERSONAL VIOLENCE 4, 8 (2020) (noting many women interviewed at an intimate-partner-violence shelter in Pennsylvania "described the potential for partner retaliation" for "terminating a pregnancy," including "one participant [who] described a partner threatening to kill her if she terminated her pregnancy.").

d. To bring a lawsuit challenging abortion restrictions, a patient would have no choice but to make public their abortion.

In contrast to patients' clear interest in maintaining the privacy of their abortion decisions, litigation inherently entails repeated public disclosure. First, a patient would need to consult with one or more attorneys and provide the type of personal information necessary to file a lawsuit. The patient would then be subject to discovery, including production of medical records and potentially sitting for a deposition. Further, if the case proceeded to trial, the patient might be called to take the stand.

Proceeding under pseudonym would not resolve these issues. The patient would still need to disclose the relevant facts of the case in public pleadings and may need to disclose their identity to the defendants or their counsel. And, as described above, anti-abortion extremists know that making public patients' abortion decisions is a powerful tactic to intimidate and shame people from having abortions; this is why, as described above, extremists take patients' pictures and write down their license plate numbers. Serving as a plaintiff in a challenge to an abortion restriction would make it much easier—and more enticing—for anti-abortion extremists to discover a patient's identity, identify them publicly, and target them with harassment and potentially violence. Finally, litigation responsibilities would take a patient's time, and their

absence from their regular routine—work, school, or home—would likely be conspicuous to others in their lives, making it challenging to remain anonymous.

II. Time pressure, delay, opportunity cost, and the low likelihood of personal benefit are genuine obstacles to a patient's ability to litigate.

Patients needing Medical Assistance cannot be expected to use their limited time, money, and emotional energy to challenge the coverage ban because those same resources are often needed to obtain abortion care itself. The "economic burdens of litigation" are a practical obstacle to asserting one's rights, particularly if the litigant may receive little benefit from the outcome of the case. *See Campbell v. Louisiana*, 523 U.S. 392, 398 (1998) (citing *Powers v. Ohio*, 499 U.S. 400, 415 (1991)). Serving as a plaintiff would require a patient to devote considerable time and financial resources to finding and meeting with lawyers, reviewing documents, assisting with discovery, potentially sitting for depositions, attending court hearings, and possibly testifying at trial. *E.g.*, Joint App'x, *June Med. Srvs. L.L.C. v. Russo*, Nos. 18-1323 & 18-1460 (U.S. Nov. 25, 2019) (showing extensive discovery, briefing, trial, and appeals). Patients would also need to delay efforts to obtain abortion care in order to initiate litigation while they have standing, adding to the expense of the procedure. And unless the patient is able to obtain judicial relief entitling them to Medical Assistance coverage during the time-window

when abortion remains a legal option—which is hardly guaranteed—they will need to find a way to finance the procedure themselves or forgo it altogether. But patients eligible for Medical Assistance generally have limited resources; without state assistance, many are hard pressed to come up with the money to pay for an abortion and its attendant costs. It is therefore preposterous to expect these patients to sacrifice their own health, economic security, and well-being to litigate, especially when abortion providers are much better positioned to do so on their behalf.

a. There is only a narrow window of time in which a patient can initiate litigation and obtain judicial relief.

The time during which a patient may obtain an abortion is limited. Under Pennsylvania law, abortion care is prohibited after 23 weeks from the patient's last menstrual period, except to prevent "death . . . or the substantial and irreversible impairment of a major bodily function." 18 PA. STAT. AND CONS. STAT. ANN. § 3211. At best, pregnancy tests can usually first detect a pregnancy three to four weeks from the first day of the last menstrual period. *See, e.g., Pregnancy: Am I Pregnant?,* CLEVELAND CLINIC, https://cle.clinic/3Aglf5X (last visited Oct. 7, 2021). But not all people are aware of their pregnancy at this point. A 2006 study found that the leading reason women obtain abortions in the second trimester of pregnancy is that they did not know they were pregnant earlier. *See* Eleanor Drey, et al., *Risk Factors Associated with Presenting for Abortion in the Second Trimester*, 107 OBSTETRICS &

GYNECOLOGY 128, 130 (2006), https://bit.ly/307ztJW.[5] There are a number of reasons why someone may not discover they are pregnant, including the absence of pregnancy symptoms like fatigue or nausea, irregular periods, or use of hormonal contraception. *See* DIANA GREENE FOSTER, THE TURNAWAY STUDY 44 (2020). Further, most abortions result from an unintended pregnancy. *See* Emily Monea & Adam Thomas, *Unintended Pregnancy and Taxpayer Spending*, 43 PERSPS. ON SEXUAL & REPRO. HEALTH 88, 89 (2011), https://bit.ly/3iAaLIA. Individuals who are not planning or intending to get pregnant may take longer to recognize it when they are. *See generally* Adejoke Ayoola, *Late Recognition of Unintended Pregnancies*, 32 PUB. HEALTH NURSING 462 (2015), https://bit.ly/3mzYuoA.

This is significant because patients would likely have standing to obtain injunctive relief[6] against the Medical Assistance program's exclusionary policy only while they are pregnant and able to seek abortion care.[7] *See Roe v. Wade*, 410 U.S. 113, 127–29 (1973). Thus, the

---

[5] More than half of the people in that study did not realize they were pregnant until they were past the first trimester of pregnancy. *See id.* at 133.

[6] In the unlikely event that a patient filed suit for damages only, this would not offer any possibility of obtaining coverage in time to receive the abortion, nor would it result in an injunction blocking the law. And, as discussed herein, many Medical Assistance patients are simply unable to pay for abortion care without that coverage.

[7] NWLC recognizes that this Court could potentially allow more individuals to sue than would likely be permitted in federal courts—such as someone enrolled in Medical Assistance with capacity for pregnancy, irrespective of whether they are currently pregnant or seeking abortion care. But that individual would still face

narrow window of time between the discovery of a pregnancy and Pennsylvania's ban on abortion after 23 weeks means that a patient would have little time in which to decide to bring a legal challenge to the exclusionary policy, let alone to find a lawyer, file suit, and obtain judicial relief. In reality, the decision to file a lawsuit will not be immediate. Even setting aside the time in which a potential plaintiff would need to weigh the pros and cons of litigation, as the Commonwealth Court recognized, most patients do not know that it is a law that is inhibiting them from obtaining Medical Assistance for an abortion until they speak with their abortion provider. Some may never learn that a law is preventing them from receiving coverage for their abortion care. Typically, abortion patients are not fully aware of state level regulations of abortion.[8] Until patients realize that a law is preventing them from accessing the abortion care they need, "[t]hose women are unlikely to sue." *Planned Parenthood*

---

significant obstacles to litigating, even if they are not also encumbered by rigid time constraints. Requiring individuals to assert in court that the coverage ban violates their rights would still subject them to the risk of stigma, harassment, and violence discussed in Part I. And even if they need not simultaneously devote resources to obtaining abortion care, potential plaintiffs enrolled in Medical Assistance would still face barriers to litigating resulting from limited income, inability to take time off work or away from caregiving obligations, and distrust of the judicial system, as discussed *infra*. Therefore, even under a more expansive definition of standing, genuine obstacles would prevent individuals from suing on their own behalf.

[8] *See* Diana Lara, et al., *Knowledge of Abortion Laws and Services Among Low-Income Women in Three United States Cities*, 17 J. IMMIGRANT & MINORITY HEALTH 1811, 1813–14 (2015); Kate Cockrill & Tracy A. Weitz, *Abortion Patients' Perceptions of Abortion Regulation*, 20 WOMEN'S HEALTH ISSUES 12, 15 (2010).

of Wis., Inc. v. Van Hollen, 738 F.3d 786, 794 (7th Cir. 2013).[9] And, once they have made this realization, they will then need to find a lawyer, who will need time to gather necessary factual support for the case, research potential claims, and draft the initial pleadings.

Further, even if the patient is able to file a lawsuit while they still have standing, they would soon face the problem of "imminent mootness" resulting from the expiration of Pennsylvania's gestational limit—or earlier if they are somehow able to obtain abortion care prior to that time or if they experience a miscarriage. *See Singleton*, 428 U.S. at 117. Although the patient may be able to continue litigating under the "capable of repetition" doctrine, *see id.*; *In re Gross*, 382 A.2d 116, 123 (Pa. 1978), the purpose will no longer be to vindicate their own rights—which will have already been deprived unless the patient is fortunate enough to obtain swift interim relief. Rather, they would be seeking to vindicate the rights of others who will be subject to the coverage ban in the future. For these reasons, the United States Supreme Court determined that the time-limited nature of abortion cases, in itself, constitutes a "genuine obstacle" to patients' ability to litigate, as a matter of law. *Singleton*, 428 U.S. at 116. Moreover, the Supreme Court concluded that "there seems little loss" in allowing physicians to assert

[9] Abortion providers, by contrast, are well aware of the laws that hinder their patients' ability to access care. For this reason, as Appellants aptly argue, they are better suited to challenge these laws.

the rights of patients because the patient-plaintiff would be acting in a representative capacity in any event once their own claim becomes moot. *Id.* at 117–18.

b. Delay caused by litigation may render abortion care unobtainable.

Because a patient must file suit before obtaining an abortion in order to have standing for injunctive relief, pursuing litigation will almost always delay the procedure. This delay, in turn, will likely make obtaining an abortion more expensive. Thus, if a patient is unable to obtain interim injunctive relief, engaging in litigation will likely make accessing an abortion more unobtainable than it already is for a patient needing Medical Assistance.

Unless a patient is able to obtain emergency, interim judicial relief entitling them to Medical Assistance before the gestational limit expires, they will be forced to pay for the abortion out of pocket or else forgo the care. In Pennsylvania, the cost of medication abortion, generally available within the first 10 weeks of pregnancy, ranges from approximately $400–$500. *See, e.g.*, FEES FOR SERVICES, PLANNED PARENTHOOD OF WESTERN PENNSYLVANIA, https://bit.ly/3amDdc8 (last visited Oct. 7, 2021). For many, even this cost is prohibitive. Abortion care can consume the monthly budget of a person with low income; even before the COVID-19 pandemic, nearly four in ten (37%) adults in the United States would have difficulty paying an unexpected $400 expense.

BD. GOVERNORS FED. RESERVE SYS., REPORT ON THE ECONOMIC WELL-BEING OF U.S. HOUSEHOLDS IN 2019, FEATURING SUPPLEMENTAL DATA FROM APRIL 2020 21 (2020), https://bit.ly/3Ft6xwc. And even if that cost is surmountable, a patient may be forced to forgo other basic necessities to afford it. One study found that one-third of women getting an abortion had to delay or forgo paying for food, bills, and even rent. *See* Rachel K. Jones, et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23 WOMEN'S HEALTH ISSUES e173, e176 (2013).

A patient who delays their abortion due to litigation will likely face increased costs.[10] After ten weeks, the often more cost-effective option of medication abortion will likely no longer be available. *See* FEES FOR SERVICES, *supra*; KAISER FAMILY FOUND., WOMEN'S HEALTH POLICY: THE AVAILABILITY AND USE OF MEDICATION ABORTION (2021), https://bit.ly/3oF4Tl9. A 2014 survey of known abortion providers throughout the United States found that the average cost of a surgical abortion at 10 weeks of gestation was $508, and it grew to a median cost of $1,195 at 20 weeks. Rachel K. Jones, et al., *Differences in Abortion Service Delivery in Hostile, Middle- Ground, and Supportive States in 2014*, 28 WOMEN'S HEALTH ISSUES 212, 215–16 (2018). Thus, filing litigation to obtain Medical Assistance for abortion, paradoxically, may

[10] Delay also carries non-financial consequences: While the risks posed by abortion are very low, they increase as a pregnancy progresses. *See* Suzanne Zane, et al., *Abortion-Related Mortality in the United States: 1998–2010*, 126 OBSTETRICS & GYNECOLOGY 258, 263 (2015).

make it less likely that the patient will ultimately be able to afford the care they need than if they had not sued at all.

Patients in need of Medical Assistance will be particularly sensitive to these costs, given their limited resources. In Pennsylvania, pregnant women are eligible for Medical Assistance only if their household incomes are under 215% of the Federal Poverty Level. *See* PENN. DEP'T. OF HUM. SERVS., MEDICAL ASSISTANCE FOR CHILDREN AND PREGNANT WOMEN (2021), https://bit.ly/3FCbSl1. Otherwise, adults that do not fall into any other eligibility category are eligible for Medical Assistance only if their household incomes are at or below 133% of the federal poverty level. *See* PENN. DEP'T. OF HUM. SERVS., MEDICAL ASSISTANCE GENERAL ELIGIBILITY REQUIREMENTS (2021), https://bit.ly/3uT1BvN. By qualifying for Medical Assistance, these patients have limited income and lack resources needed to obtain an abortion, let alone to pursue litigation.

c. Litigation would force patients to divert their limited financial and nonfinancial resources away from overcoming barriers to abortion.

Participation in litigation would require a patient to meet with counsel and attend court proceedings, which may require them to take time off work and away from caregiving obligations, travel long distances, and devote considerable emotional energy to coordinating these logistics. Accessing abortion care requires a similar expenditure of time, money, and emotional energy. Thus, litigation carries a substantial opportunity

cost: patients will need to divert their finite resources—money, access to transportation, vacation or sick days off work, or child care—to attending to their litigation responsibilities rather than to accessing abortion care. And even if a patient obtains judicial relief—and thus receives Medical Assistance to pay for the procedure itself—they may no longer have the resources they need to meet these attendant costs of abortion care. What is more, the delay caused by litigation will likely increase these costs. Thus, patients will likely prioritize obtaining the care they need, and they should not be expected to divert their limited resources toward litigation.

To begin, individuals who qualify for Medical Assistance are least likely to have access to a vehicle—necessary in many parts of Pennsylvania to get to an abortion clinic or to meetings with counsel or the court. In 2017, those in Pennsylvania with household incomes under $25,000 had just .77 vehicles per household, compared to 2.1 vehicles per household for those with incomes above $25,000. *See* NWLC calculations using U.S. Dep't of Transp., Fed. Highway Admin., 2017 National Household Travel Survey, https://nhts.ornl.gov/. This means that if these patients have access to a vehicle at all, they likely share it with someone else in their household. A patient with finite or sporadic access to a shared vehicle is unlikely to prioritize using their limited time with it for litigation-related travel as opposed to obtaining the care they need.

This access is crucial, however, because patients often must travel long distances to obtain abortion care. As of 2017, 85% of Pennsylvania

counties had no abortion provider, and 48% of women lived in those counties. *See* GUTTMACHER INSTIT., STATE FACTS ABOUT ABORTION: PENNSYLVANIA (2021), https://bit.ly/3aipvY8. The majority of Pennsylvania abortion providers are located in the metro regions of Philadelphia or Pittsburgh, so those living in rural areas will face the most burdensome travel distances. *See* NAT'L ABORTION FED'N., FIND A PROVIDER: PENNSYLVANIA, https://bit.ly/3iHsDkK (last visited Oct. 7, 2021). For example, a pregnant person living in McKean County would have to travel approximately six hours roundtrip to get an abortion at their nearest provider in Pittsburgh. *See* Driving Directions from Smethport, PA to Pittsburgh, PA, GOOGLE MAPS, https://bit.ly/3mqsFyn.

In the absence of consistent vehicle access, those individuals will have to shoulder additional travel costs. For example, without a personal vehicle, a pregnant person living in McKean County would need to pay for a cab or ride share service to Bradford, and then pay $162 for a round-trip bus ticket to Pittsburgh. *See* Round-trip Ticket from Bradford, PA to Pittsburgh, PA, GREYHOUND, https://bit.ly/3lkzEcQ (insert "Bradford, PA" and "Pittsburgh, PA" in "From" and "To" fields, respectively, and follow "SEARCH" hyperlink; choose outgoing/return trip dates, click $78 price for each trip, click "BOOK THIS FARE"; come to payment detail page with $161.98 ticket summary). But there is only one bus traveling between each destination per day; this bus does not arrive in Pittsburgh until 9:10 PM, and the return bus departs at 4:55 AM. *Id.* So, the patient

would also need to find or pay for two nights of housing in Pittsburgh, for before and after their appointment. The average cost for a hotel room in Pittsburgh is $170 per night. BUDGET YOUR TRIP, TRAVEL BUDGET FOR PITTSBURGH, PA, https://bit.ly/2Ys7Pab (last visited Oct. 7, 2021).

Further, participation in litigation—which for the reasons described *supra* will delay access to care—will translate into increases in these travel times. As a pregnancy progresses, there are fewer providers available to provide abortion care. This means that all of the attendant financial and logistical barriers to abortion described here will likely increase if a patient delays seeking an abortion to litigate a challenge to the Medical Assistance coverage exclusion. For example, for a pregnant person in Harrisburg seeking abortion care after 14 weeks into pregnancy, there is no local clinic available to them. *See* FIND A PROVIDER: PENNSYLVANIA, *supra*; PLANNED PARENTHOOD KEYSTONE, ABORTION SERVICES, https://bit.ly/3iFzIlM (last visited Oct. 7, 2021). The nearest clinic offering care at that point in pregnancy requires an approximately three-hour roundtrip drive. *See* FIND A PROVIDER: PENNSYLVANIA, *supra;* ALLENTOWN WOMEN'S CENTER, SURGICAL ABORTION, https://bit.ly/3ak8fSi (last visited Oct. 7, 2021); Driving Directions from Harrisburg, PA to Allentown, PA, GOOGLE MAPS, https://bit.ly/3iCxwLR. A longer roundtrip means that the patient will need to devote more time to obtaining an abortion—time that they cannot afford to spend away from work and caregiving obligations.

Indeed, many abortion patients have little ability to take time off work to travel to obtain abortion care, let alone to satisfy the demands and responsibilities of litigation. Nearly six in ten female Medicaid beneficiaries nationwide work, often in low-paid or part-time jobs in industries that fail to provide health insurance or paid leave, like restaurants and food service, education, and home-health care. *See* IVETTE GOMEZ, ET AL., KAISER FAMILY FOUND., MEDICAID WORK REQUIREMENTS: IMPLICATIONS FOR LOW INCOME WOMEN'S COVERAGE (2021), https://bit.ly/3oYagfx. Of the women and girls on Medical Assistance that are of reproductive age, many work low-wage (31.5%) or part-time (30.0%) jobs. NWLC calculations using 2015–2019 American Community Survey, accessed through Ruggles, et al., IPUMS USA.

Arranging time off is particularly difficult for these workers. Workers in low-wage and part-time jobs often have volatile work schedules that vary weekly or are given on short notice.[11] Moreover, Pennsylvania does not mandate that employers provide paid vacation or sick leave, and low-paid and part-time jobs in particular lack these benefits. PA. DEP'T OF LAB. & INDUS., GENERAL WAGE AND HOUR QUESTIONS (2021), https://bit.ly/3le364o. Nationally, only 33% of people

[11] *See* CLAIRE EWING-NELSON, NAT'L WOMEN'S LAW CTR., PART-TIME WORKERS ARE PAID LESS, HAVE LESS ACCESS TO BENEFITS—AND MOST ARE WOMEN 5 (2020), https://bit.ly/3AfiD8f; JULIE VOGTMAN & JASMINE TUCKER, NAT'L WOMEN'S LAW CTR., COLLATERAL DAMAGE: SCHEDULING CHALLENGES FOR WORKERS IN LOW-WAGE JOBS AND THEIR CONSEQUENCES 12 (2017), https://bit.ly/3Ahadx2.

with wages in the lowest 10% of earnings have paid sick days. *See* Elise Gould, *Two-Thirds of Low-Wage Workers Still Lack Access to Paid Sick Days During an Ongoing Pandemic*, ECON. POL'Y INST. (Sept. 24, 2021), https://bit.ly/2YtHFDi. Those behind a recent effort in Pennsylvania to enact paid sick leave estimated that the policy would help 400,000 people in the state—particularly low-wage workers. *See Gov. Wolf Calls for Paid Sick and Family Leave for Workers*, GOV. TOM WOLF (Aug. 31, 2020), https://bit.ly/2YBYQ63. For individuals in jobs without paid leave or flexible and predictable work schedules, taking time off to meet litigation demands—or to spend the time needed to access abortion care—can mean forgoing income or jeopardizing employment, thereby threatening their economic security.

Additionally, accessing child and dependent care in Pennsylvania is difficult—but often necessary both to obtain abortion care and to take on the responsibilities of litigation, as most people obtaining an abortion already have children.[12] Nationwide, Medicaid beneficiaries who do not work typically assume caregiving obligations, or else are in school or are ill or disabled, all of which pose obstacles to litigating. *Gomez*, *supra*. In Pennsylvania, 57% of people live in a child care desert. *See* CTR. FOR AM.

---

[12] *See* JENNA JERMAN, ET AL., GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008 7 (John Thomas ed. 2016), https://bit.ly/3AgxpM1; Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1906 (2017).

PROGRESS, CHILDCARE DESERTS: PENNSYLVANIA, https://bit.ly/3AmJ63N (defining "childcare desert" as "a census tract with more than 50 children under age 5 that contains either no child care providers or so few options that there are more than three times as many children as licensed child care slots."). Among people in child care deserts, 56% are in the lowest-income neighborhoods. *Id.* And 73% of rural families live in child care deserts. *Id.* The problem got worse during the COVID-19 pandemic: Between March and September 2020, more than 260 licensed child care programs across Pennsylvania permanently closed. *See* Ed Mahon, *Hundreds of Pa. Child-Care Centers Have Closed, and Some Fear It Will Get Worse*, SPOTLIGHT PA (Oct. 8, 2020), https://bit.ly/2YC0apx.[13]

What is more, child care is expensive: In 2019, the annual cost of full-time care for an infant in center-based child care in Pennsylvania was $12,308. *See* CHILD CARE AWARE OF AM., PICKING UP THE PIECES: BUILDING A BETTER CHILD CARE SYSTEM POST COVID-19 2–3 (2020), https://bit.ly/3iC8xs9. And although as of May 2020 individuals making 200% of the federal poverty level in Pennsylvania may qualify for child care assistance through the Child Care and Development Block Grant (the major federal child care assistance program), they still may not receive it due to insufficient funding. KAREN SCHULMAN, NAT'L WOMEN'S

[13] Although federal and state relief funds have helped to prevent more closures, clinics continue to experience staffing shortages and are serving fewer children. NAT'L ASS'N FOR THE EDUC. OF YOUNG CHILDREN, STATE SURVEY DATA: CHILD CARE AT A TIME OF PROGRESS AND PERIL 38 (2021), https://bit.ly/3iIJfsy.

LAW CTR., ON THE PRECIPICE: STATE CHILD CARE ASSISTANCE POLICIES 2020 3, 27 (2021), https://bit.ly/3Br5lqz. As of early 2020, just prior to the onset of the COVID-19 pandemic, 2,111 Pennsylvania children were on a waiting list for child care assistance. *Id.* at 29.

Women of color, in particular, will face obstacles to both litigating and obtaining the care they need. Not only are women of color of reproductive age disproportionately represented in the Medical Assistance program,[14] but well over half of abortion patients in Pennsylvania are Black or Hispanic.[15] At the same time, women of color are both substantially overrepresented in low-paying jobs and are more likely to be the breadwinner or a co-breadwinner in their households, making their jobs essential to their families' economic security: In 2018, Latina and Native women made up a share of the low-paid workforce that was twice as large as their share of the workforce overall; for Black women that ratio was 1.5 and for Asian American and Pacific Islander women 1.3, versus 1.1 for white women. JASMINE TUCKER & JULIE VOGTMAN, NAT'L WOMEN'S LAW CTR., WHEN HARD WORK IS NOT ENOUGH: WOMEN IN LOW-PAID JOBS 3 (2020), https://bit.ly/3a8BKHt. And 85% of

[14] 44.9% of women and girls of reproductive age on Medical Assistance in Pennsylvania are people of color, although they comprise only 27.7% percent of women and girls of reproductive age in Pennsylvania. *See* NWLC calculations using 2015–2019 American Community Survey, accessed through Ruggles et al., IPUMS USA.

[15] PA. DEP'T OF HEALTH, 2019 ABORTION STATISTICS 1 (2020), https://bit.ly/3Fqoz22.

Black, 74% of Native, 61% of Hispanic, and 56% of Asian mothers are the breadwinner or a co-breadwinner in their households. *See* Sarah Jane Glynn, *Breadwinning Mothers are Critical to Families' Economic Security*, CTR. FOR AM. PROGRESS (March 29, 2021), https://ampr.gs/3Bnc3hx. For many abortion patients of color, taking time off work and away from their families to litigate is simply not an option, particularly if they are simultaneously trying to access the care they need.

In sum, in order to access care, many patients will need to pay for and coordinate transportation, lodging, time off work, and child care. Even those who do not need to travel will still need to shoulder many of these costs, which can be prohibitive for many—particularly among those on Medical Assistance. As one court observed, "the additional costs associated with travel—including gas, tolls, hotel room stays, bus tickets, lost wages and child care—may reach a tipping point where they become too great for a household to bear and the woman would not be able to get the abortion that she desired." *See Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 991 (W.D. Wis. 2015) (internal quotation marks and alterations omitted), *aff 'd sub nom. Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, (7th Cir. 2015). Given this, patients cannot be expected to divert their precious resources to litigating rather than obtaining the abortion care they need.

d. People with low incomes are particularly unlikely to turn to the civil justice system to remedy deprivations of their rights.

People who are struggling to make ends meet are unlikely to turn to the civil justice system to solve their problems. In a national study, the Legal Services Corporation found that people with low incomes facing a situation with legal implications turned to the civil justice system only 22% of the time in a given year. *See* LEGAL SERV. CORP., THE JUSTICE GAP: MEASURING THE UNMET CIVIL LEGAL NEEDS OF LOW-INCOME AMERICANS 33 (2017), https://bit.ly/3mvmoSa. This problem is not only attributable to the well-documented lack of legal providers for people with low and middle incomes; a subsequent study revealed that people with low incomes, and particularly people of color, were dissuaded from pursuing legal action because of their pervasive distrust of the civil legal system (which nonlawyers often conflate with the criminal legal system), distrust of public institutions in general, and ardent belief in self-sufficiency. *See* Sara Sternberg Greene, *Race, Class, and Access to Civil Justice*, 101 IOWA L. REV. 1263, 1269–70, 1289–98 (2016). In particular, Black respondents were least likely to trust the legal system, and therefore least likely to turn to the courts for civil legal issues. *Id.* at 1311–12.

Litigation success does not provide an adequate incentive to overcome this skepticism—or to overcome the financial, emotional, and

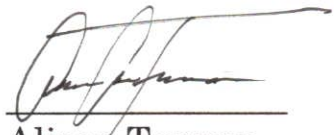
logistical barriers described above—because it is quite reasonable for a patient to be concerned that litigation will not yield relief before the expiration of the gestational limit. Final relief will take years to achieve. This case was filed in January 2019, and it is nowhere near resolution. As an example of the length of time it might take to receive a final decision on the merits, in *June Medical Services v. Russo*, 140 S. Ct. 2103 (2020), Louisiana's Act 620 was first challenged in August 2014, but the U.S. Supreme Court did not issue its decision invalidating the measure until nearly six years later, in June 2020. And there is no guarantee that interim relief will come in time. For example, in *Fischer v. Department of Public Welfare*, although the original action was filed in the Commonwealth Court on February 12, 1981, a preliminary injunction did not issue until August 10th of that year. 502 A.2d 114, 116 (Pa. 1985).

CONCLUSION

The Commonwealth Court's decision does not recognize the reality of many patients' lives. It is, of course, *possible* that some patients might, despite these odds, pursue their constitutional rights in court, as the patient-plaintiffs did in *Fischer v. Department of Public Welfare*, 444 A.2d 774 (Pa. 1982). But the Commonwealth Court could cite no precedent supporting its implicit conclusion that a litigant may assert the rights of a third party only when the obstacles the third party faces are insurmountable. Indeed, in *Singleton*, the U.S. Supreme Court required

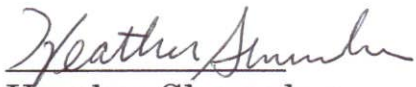
only that the obstacles faced be "genuine." 428 U.S. at 116–17. Patients cannot be expected to risk their ability to obtain the care they need, their health and economic security, their privacy, and potentially their safety, with no guarantee of any reward, when Appellants are much better suited to assert these claims on their patients' behalf. The Commonwealth Court erred in failing to consider the many genuine obstacles that prevent patients needing Medical Assistance from filing a legal challenge such as this one. Accordingly, this Court should reverse the decision below.

Respectfully submitted,



Alison Tanner
DC ID# 230504

Michelle Banker
DC ID# 1003535



Heather Shumaker
DC ID# 888304022
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle NW, Suite 800
Washington, DC 20036
(202) 588-5180
atanner@nwlc.org
mbanker@nwlc.org
hshumaker@nwlc.org

/s/ Jim Davy

Jim Davy
PA ID# 321631
ALL RISE TRIAL & APPELLATE
P.O. Box 15216
Philadelphia, PA 19125
(609) 273-5008
jimdavy@allriselaw.org

Counsel for *Amicus Curiae*

CERTIFICATE OF COMPLIANCE WITH WORD LIMIT

I hereby certify pursuant to Pa.R.A.P. 531 that this brief does not exceed 7,000 words.

CERTIFICATE OF COMPLIANCE

I hereby certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

CERTIFICATE OF SERVICE

I hereby certify that on this 13th day of October, 2021, a true and correct copy of the foregoing Brief of *Amicus Curiae* was served on the Parties via PACFile.

/s/ *Jim Davy*
Jim Davy

Dated: October 13, 2021