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26 MAP 2021

ALLEGHENY REPRODUCTIVE HEALTH CENTER, *et al.*,
Appellants,

vs.

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES, *et al.*,
Appellees

BRIEF OF *AMICI CURIAE* NEW VOICES FOR REPRODUCTIVE JUSTICE AND PENNSYLVANIA AND NATIONAL ORGANIZATIONS ADVOCATING FOR BLACK WOMEN AND GIRLS IN SUPPORT OF APPELLANTS ALLEGHENY REPRODUCTIVE HEALTH CENTER, ET AL.

APPEAL FROM THE ORDERS OF THE COMMONWEALTH COURT AT NO. 26 MD 2019 DATED JANUARY 28, 2020, AND MARCH 26, 2021

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LIST OF *AMICI CURIAE*

New Voices for Reproductive Justice
In Our Own Voice: National Black Women's Reproductive Justice Agenda
Black Feminist Future
Black Girl's Guide to Surviving Menopause
Black Mothers in Power
Black Women For Wellness
Dignity Act Now Collective
Feminist Women's Health Center
Gwen's Girls and the Black Girls Equity Alliance
Let's Get Free: The Women & Trans Prisoner Defense Committee
Life House Lactation & Perinatal Services, LLC
Monica McLemore, R.N., MPH, Ph.D.
National Asian Pacific American Women's Forum
National Birth Equity Collaborative
Oshun Family Center
Philadelphia Chapter of NOW
Philadelphia Commission for Women
Rev. Deneen Robinson
SisterLove, Inc.
SisterReach
SPARK Reproductive Justice NOW!, Inc.
Womanist Working Collective
Women With a Vision, Inc.

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INTERESTS OF AMICUS CURIAE

Amici are 23 organizations working in Pennsylvania and the U.S. to ensure Reproductive Justice and the health and well-being of Black women and girls. Lead *amicus* New Voices for Reproductive Justice ("New Voices") is a Pennsylvania non-profit organization that works through leadership development, community organizing, policy advocacy, and culture change to amplify the voices of Black women and girls, who demand and deserve access to quality and culturally responsive health care.[1] New Voices was instrumental in the passage of the Affordable Care Act, its implementation in Pennsylvania, and the expansion of Medicaid in Pennsylvania.

Comprehensive healthcare access is critical in Pennsylvania, where health outcomes for Black women and girls are abysmal by every measure, from life expectancy to maternal health. These disparities impact Black Pennsylvanians not because of an inherent problem with Black people – as has been harmfully asserted for over 150 years – but because of historical and present-day intersectional racial and gender-based oppression. Medicaid restrictions, like Pennsylvania's Coverage Ban, are an ongoing legacy of that discrimination. These restrictions undermine Reproductive Justice – the human right to control our bodies, sexuality, gender, work, reproduction, and ability to form our families.

[1] Statements of interest for individual *amici* are set forth in Appendix A. No person or entity other than New Voices and counsel paid for or authored this brief.

New Voices and all *amici* share the goal that Black women and girls live long, healthy, and joyful lives – goals that are impeded when Medicaid restrictions relegate Black women and girls to second-class citizenship in health care.

ARGUMENT

I. INTRODUCTION AND SUMMARY OF ARGUMENT.

Pennsylvania's Medicaid program violates the Pennsylvania Constitution's guarantee of equality by failing to cover abortion care.[2] That violation ("Coverage Ban") has consequences for all Medicaid beneficiaries in Pennsylvania, but those consequences fall more heavily on Black women and girls.[3] This is because Black women and girls, despite high levels of workforce participation and educational attainment, face economic disadvantage and health disparities that are the ongoing legacy of structural racism and gender discrimination. Pennsylvania's Medicaid program should redress, rather than entrench, such disparate harms.

Black women and girls in Pennsylvania – and throughout the U.S. – suffer from health disparities present in no other well-resourced nation in the world. These disparities affect Black women and girls regardless of socio-economic status, and are compounded for those who need publicly-funded health care. In a context where

[2] Pennsylvania bans coverage of abortion care except in cases of rape or incest, or when the abortion is necessary to avert the death of the pregnant woman. *See* 18 Pa. C.S. § 3215(c) & (j).

[3] *Amici* are organizations that work to advance Reproductive Justice for Black women and girls. Centering those communities is not intended to exclude Black transgender and gender non-conforming Pennsylvanians who are also harmed by the Coverage Ban.

improving maternal and lifelong health of Black women and girls remains a struggle, singling out any health care – but especially reproductive health care – for a coverage ban is unconscionable. Instead of restricting access, the Commonwealth should ensure that health care is accessible to all.

Similarly, the Commonwealth should work to eliminate poverty. This includes ensuring living wages, increasing access to paid leave, providing meaningful, accessible childcare options, and addressing structural racism and gender discrimination that have led to inequitable pay gaps and wealth disparities. Black women and girls in Pennsylvania are more likely to work in low-wage jobs; more likely to be paid less for the same work than their white and/or male counterparts; and far less likely to have the means to weather a financial blow to a family – like a costly healthcare need – than white women. This means they are more likely to access health care through the Medicaid program, and less likely to be able to pay out-of-pocket for abortion care.

The Coverage Ban means that Black women and girls who need abortion care are forced to forego or delay care while they raise the money – sometimes giving up critical necessities – to cover the costs. If they are also an immigrant, experiencing intimate partner violence, or enduring additional discrimination because of their gender identity or sexual orientation, the challenges of obtaining needed abortion

care are compounded. Delay or denial of abortion care threatens the well-being of the person who needs an abortion.

Disparate health risks for Black women and girls are even more obvious now. The COVID-19 pandemic has shown that structural discrimination uniquely exposes Black communities to economic strain, health inequities, and death. While COVID-19 created an economic crisis throughout the world, in the U.S. "the roles of both race and gender proved to be disastrous for employment losses for Black women," who have higher labor force participation and thus are more vulnerable to economic downturn. Michelle Holder et al., *The Early Impact of COVID-19 on Job Losses Among Black Women in the United States*, Levy Economics Institute 17 (July 18), http://www.levyinstitute.org/pubs/wp_963.pdf. The pandemic has also increased the need for and the challenges of obtaining abortion care: unintended pregnancies have become more likely as existing structural inequities have worsened, creating more barriers to contraceptive access. And the pandemic has exacerbated the challenges of paying out-of-pocket for abortion care, underscoring the need for Medicaid coverage.

II. HEALTH DISPARITIES HARM BLACK WOMEN AND GIRLS.

A. Black people experience appalling health disparities.

Racial disparities in health outcomes in the U.S. are well-documented and stark. Black Americans are twice as likely to die at earlier ages from all causes. Centers for Disease Control and Prevention, *African American Health*,

https://www.cdc.gov/vitalsigns/aahealth/infographic.html#graphic (last visited September 10, 2021). Black people experience serious illnesses earlier and have higher rates of morbidity than white people. *Id*. Stated differently, "almost 100,000 Black persons die prematurely each year who would not have died if there were no racial disparities in health." David R. Williams and Selena Mohammed, *Discrimination and Racial Disparities in Health: Evidence and Needed Research*, 32 J. Behav. Med. 20 (2008). And the COVID-19 pandemic "has lowered the life expectancy of Black Americans by three years, compared to a one-year decrease in life expectancy in the general public." Zoe Read, *New Pa. initiative seeks to identify and reduce health disparities*, WHYY (March 17, 2021), https://whyy.org/articles/new-pa-initiative-seeks-to-identify-and-reduce-causes-of-health-disparities/.

Racial disparities are as severe in Pennsylvania, where Black people have worse health outcomes, shorter life expectancy, and higher death rates than white people. *Id*.; *see also* Office of Health Equity, *The State of Health Equity in Pennsylvania* 11 (Jan 2019), https://www.health.pa.gov/topics/Documents/Health%20Equity/The%20State%20of%20Health%20Equity%20in%20PA%20Report%20FINAL.pdf. These disparities have myriad causes, including lack of access to health care, race and gender discrimination, and geographic isolation. *Id*.; *see also* Elizabeth J. Brown et al., *Racial Disparities in Geographic Access to Primary Care in Philadelphia*, 14 Health Affairs 1 (2016) (finding "stark racial disparities" in

access to primary care across Philadelphia neighborhoods). For Black women and girls, the impact of past policies – from redlining to school segregation – and current experiences of discrimination directly affect their health and well-being. *The State of Health Equity in Pennsylvania*, *supra* p. 22.

B. Black women in Pennsylvania are more likely to die from pregnancy-related causes.

The U.S. has worse maternal health outcomes than any other well-resourced nation. *See* Marcela Howell et al., *Addressing American's Black Maternal Health Crisis*, In Our Own Voice: National Black Women's Reproductive Justice Agenda 1 (2020), http://blackrj.org/wp-content/uploads/2020/04/6217-IOOV_Maternal_trifol.pdf ("U.S. women are more likely to die from pregnancy-related complications than women in 45 other countries…"); *see also* Governor Tom Wolf, *Governor Wolf Signs Bill to Investigate Maternal Deaths* (May 9, 2018), https://www.governor.pa.gov/newsroom/governor-wolf-signs-bill-investigate-maternal-deaths/ (Pennsylvania's maternal mortality rate has more than doubled since 1994). Disturbingly, the U.S. is "the only country with an advanced economy where the [maternal mortality rate] is getting worse." Pilar Herrero et al., *Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care*, Black Mamas Matter Alliance 9 (2018), https://www.reproductiverights.org/sites/default/files/documents/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages.pdf. *Amici* note that true Reproductive

Justice would mean that the Commonwealth sets its sights – and focuses its policies – on ensuring that Black women and girls, and all pregnant people, have the same optimal maternal health outcomes as those successful nations (not merely achieving the same outcomes of their white American counterparts).

But as of this writing, Black women in the U.S. experience appalling disparities in maternal health. From 2014 to 2017, Black women were *three times* more likely than white women to die from pregnancy-related complications. Centers for Disease Control and Prevention, *Reproductive Health: Pregnancy Mortality Surveillance System*, https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm#race-ethnicity (last visited September 29, 2021). And they are twice as likely as white women to experience other severe pregnancy-related health complications. Howell et al., *Addressing America's Black Maternal Health Crisis*, *supra*, p. 1; *see also Black Mamas Matter*, *supra*, p. 21.

Pennsylvania fares no better: from 2011 to 2015, Black women in Pennsylvania died from pregnancy and childbirth at a rate more than three times that of white women. *See The State of Health Equity in Pennsylvania, supra.* Eleven percent of women in Pennsylvania are Black, yet Black women account for 31% of all pregnancy-related deaths. Mashayla Hays, *Let's Make Black Women's Maternal Mortality a Priority in PA*, Philadelphia Inquirer, (Dec. 20, 2018),

https://www.inquirer.com/opinion/commentary/black-women-maternal-mortality-philadelphia-pennsylvania-20181220.html. In Philadelphia, Black women comprised three-quarters of all pregnancy-related deaths between 2010 and 2012. Alexandra Grizos and Janet Weiner, *Eight Steps to Preventing Pregnancy-Related Mortality in Philadelphia*, Penn LDI (June 30, 2015), https://ldi.upenn.edu/eight-steps-preventing-pregnancy-related-mortality-philadelphia. These grossly disparate outcomes are attributable to several factors, including systemic racism within the healthcare system. *See, e.g.*, Hays, *supra* (explaining Black women "struggle to find culturally competent and responsive doctors, all while navigating [healthcare] systems where racism is at play, and where black providers are underrepresented"); *see also Eight Steps*, *supra*.

These disparities, and their underlying causes, are not indelible. There are numerous ways to promote health equity, including improving access to responsive, unbiased, community-influenced health care. *See, e.g.*, Cynthia Prather et al., *The Impact of Racism on the Sexual and Reproductive Health of African American Women*, 25 J. of Women's Health (2016), https://www.liebertpub.com/doi/10.1089/jwh.2015.5637 (explaining "it is critical to examine how long-standing and even some contemporary statutes (i.e., welfare system, access to quality health care) ultimately impact the health and well-being of

marginalized populations, including African American women.”). But rather than promoting racial and gender equity, the Coverage Ban exacerbates these disparities.

C. Barriers and gaps in contraceptive access increase Black women and girls’ risks of unintended pregnancy.

While all Medicaid beneficiaries are more likely to experience gaps in contraception use that increase the risk of unintended pregnancy, Black women and girls are disparately likely to experience those gaps, regardless of income level. Jennifer J. Frost et al., *Factors Associated with Contraceptive Use and Nonuse, United States, 2004*, 39 Perspectives on Sexual & Repro. Health 90 (2007), https://www.guttmacher.org/journals/psrh/2007/factors-associated-contraceptive-use-and-nonuse-united-states-2004. The reasons for this disparity include funding cuts to programs that provide free and low-cost contraception; the expenses of obtaining contraception; and the dearth of reproductive health care providers in low-income communities and communities of color. *See, e.g.*, Alisa Von Hagel & Daniela Mansbach, Scholars Strategy Network, *The Abortion Barriers and Needs of Black Women* (Apr. 26, 2018), https://scholars.org/brief/abortion-barriers-and-needs-black-women. Black women and girls are also more likely to have had negative and racist encounters with medical providers, contributing to racial disparities in unintended pregnancies. *See* Christine Dehlendorf et al., *Racial/Ethnic Disparities in Contraceptive Use*, 210 Am. J. Obstet. Gynecol. 526e1 (2014).

D. Health disparities are compounded for Black women and girls who are immigrants or survivors of sexual and intimate partner violence.

Economic insecurity and the need for Medicaid coverage for abortion care is exacerbated by the realities of peoples' lives. A person is not singularly a woman, low-income, Black, or an immigrant; they experience these identities simultaneously.[4] They may have experienced sexual abuse or intimate partner violence; they may have lost a job because of discrimination based on their gender identity or sexual orientation. The intersection of these identities and experiences compounds the disparities that Pennsylvanians experience as a result of the Coverage Ban.

1. Black women and girls who are immigrants face additional barriers to health care access.

The health care experiences of Black women and girls who are immigrants, whether from African nations, the Caribbean, Europe, or other countries, are seriously under-studied. *See, e.g.*, Ogbonnaya Omenka et al., *Understanding the Health Care Experiences and Needs of African Immigrants in the United States: A Scoping Review*, 20 BMC Public Health 27 (2020). However, it is well understood that immigrant women, especially those who are living with low-incomes and need language access, face significant barriers to health care. *See, e.g.*, Sheila Desai et al.,

[4] *See* Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. Chi. Legal F. 139 (1989).

Characteristics of Immigrants Obtaining Abortions and Comparison with U.S.-Born Individuals, 28 J. Women's Health 1505 (Nov. 2019). Those barriers impede access to abortion care: the limited data indicates that the majority of immigrants needing abortion care were living near or at the poverty level. *Id*. at 1506.

Immigrants also face threats to their immigration status as reprisal for seeking medical care. *Id.* at 1505. This threat of immigration consequences prevents many immigrants from getting needed health care. Krista M. Perreira et al., *Barriers to Immigrants' Access to Health and Human Services Programs*, Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy, U.S. Dep't of Health and Human Services 11 (May 2012), https://aspe.hhs.gov/sites/default/files/pdf/76471/rb.pdf. Women of color immigrants are among the most likely to be deterred by the risk of immigration consequences. *See* Desai et al., *supra* at 1509 (immigrant women of color's access to reproductive health care is impeded because of the "pervasive history of racism and xenophobia in the [U.S.]").

This has held true through the pandemic: 49% of Black women immigrant domestic workers reported in a recent study that they feared seeking assistance from state, federal, or local governments because of immigration status. Marc Bayard and Kimberly Freeman Brown, *Black Immigrant Domestic Workers in the Time of COVID-19*, Institute for Policy Studies, https://ips-dc.org/black-immigrant-

domestic-workers-covid-19/ (last visited October 7, 2021). These fears are, unfortunately, well-founded. Black immigrants are more likely to be policed, criminalized, detained, and deported than other immigrants. Andrea J. Ritchie and Monique W. Morris, *Center Black Women, Girls, Gender Nonconforming People, and Fem(me)s In Campaigns for Expanded Sanctuary and Freedom Cities*, National Black Women's Justice Institute 8 (2017), https://forwomen.org/wp-content/uploads/2017/09/Centering-Black-women-final-draft6.pdf.

2. Black women and girls who are survivors of sexual abuse and intimate partner violence face additional barriers to obtaining abortion care.

Black women and girls who are survivors of sexual abuse and intimate partner violence ("IPV") also face increased risk of negative health outcomes, and unique barriers to obtaining reproductive health care.

a) Experiences of sexual abuse and assault are linked to adverse health outcomes for Black women and girls.

In a landmark report, Black Women's Blueprint described the impact of sexual abuse and assault on the health and well-being of Black women in pregnancy and childbirth. Farah Tanis et al., *The Sexual Abuse to Maternal Mortality Pipeline*, Black Women's Blueprint (July 2019), https://drive.google.com/file/d/1S3qcOb0oCvYcAjttaldgwbH_ErwovSzd/view.

The report found that nearly 70% of Black girls surveyed reported experiencing sexual violence before age 18. *Id*., p. 5. Those experiences have profound after-effects: Black women, girls, transgender, and gender non-conforming people who have experienced sexual abuse suffer health disparities later in life. *Id*., pp. 36-45. While calling for additional research, the report explains that trauma affects interactions with healthcare providers, making it more likely that survivors will delay seeking reproductive health care, or will be harmed when they do. *Id*.

b) Survivors of IPV face additional barriers to accessing health care.

Survivors of IPV are also harmed by the Coverage Ban because they face additional, abuser-generated obstacles to obtaining health care.

Nearly one in four U.S. women will experience severe IPV in her lifetime. S.G. Smith et al., National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, *The National Intimate Partner and Sexual Violence Survey: 2010-2012 State Report* 120 (2017). From 2008 – 2018, more than 1,600 Pennsylvanians died from domestic violence-related incidents. Pennsylvania Coalition Against Domestic Violence, *2018 Domestic Violence Fatality Report* 3 (2018), https://www.pcadv.org/wp-content/uploads/2018-Fatality-Report_web.pdf. IPV is an even more common experience for women of color: four in ten Black and Native American women, and one in two multiracial women, will be raped, physically assaulted, or stalked by an intimate partner in their lifetime. Michele C.

Black et al., National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* (2011), http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.

Unintended pregnancy is a risk of IPV, as abusive partners frequently use "reproductive coercion" as a tool of control. Reproductive coercion describes conduct, ranging from rape to sabotaging birth control, that abusers use to force a partner to become pregnant. Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 Contraception 316 (2010). Black young women and girls experience higher rates of reproductive coercion. Amber Hill et al., *Reproductive Coercion and Relationship Abuse Among Adolescents and Young Women Seeking Care at School Health Centers*, 134 Obstetrics & Gynecology 351, 357 (2019). Although reproductive coercion may take place in a non-violent relationship, in the context of IPV the prevalence is higher, the severity is higher, and the risk of unintended pregnancy is doubled. Jonel Thaller and Jill Theresa Messing, *Reproductive Coercion by an Intimate Partner: Occurrence, Associations, and Interference with Sexual Health Decision Making*, 42 Health & Soc. Work e11 (2016).

And when survivors of IPV become pregnant, abusers' conduct makes it harder for them to obtain abortion care. Abusers use a range of tactics to dominate

and isolate a partner, including monitoring the survivors' activities and communications with others, Karla Fischer et al., *The Culture of Battering and the Role of Mediation in Domestic Violence Cases*, 46 S.M.U. L. Rev. 2117, 2126-27 (1993); restricting the survivor's access to financial resources, *see* Adrienne E. Adams, *Measuring the Effects of Domestic Violence on Women's Financial Well-Being*, CFS Research Brief 2011-5.6, at 1 (2011); and withholding funds to cover co-pays or to purchase a prescription, *see* Karen Oehme et al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 Geo. J. Gender & L. 613, 633 (2014). Public policy should counteract abuser-generated barriers to health care for IPV survivors, rather than impose additional barriers through the programs designed to ensure health care access.

III. BLACK WOMEN AND GIRLS EXPERIENCE ECONOMIC DISPARITIES THAT INCREASE THE NEED FOR COMPREHENSIVE MEDICAID COVERAGE.

In addition to health disparities, Black women and girls are more likely to experience economic disparities, necessitating their participation in Medicaid.

A. Black women and girls are more likely to need Medicaid coverage.

Given the racial and gender disparities of economic insecurity, it is not surprising that Medicaid enrollees are disproportionately Black women and women of color. Indeed, 31% of Black women of reproductive age are enrolled in Medicaid, compared to only 16% of white women. Adam Sonfield, *Why Protecting Medicaid*

Means Protecting Sexual and Reproductive Health, 20 Guttmacher Pol'y Rev. 39, 40 (2017). More than half of Black girls, from infants to 17 years of age, are insured through Medicaid. National Partnership for Women & Families, *Fact Sheet: Black Women Experience Pervasive Disparities in Access to Health Insurance* (April 2019), https://www.nationalpartnership.org/our-work/resources/health-care/black-womens-health-insurance-coverage.pdf. And 43% of non-elderly Black Pennsylvanians rely on Medicaid coverage, compared to only 16% of their white counterparts. *See* Kaiser Family Foundation, *Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity*, https://www.kff.org/medicaid/state-indicator/rate-by-raceethnicity-3.

B. Black women experience higher rates of economic insecurity.

In Pennsylvania, 76% of the Black families living in poverty are headed by single women. *See* Marcela Howell and Michelle Batchelor, *Pennsylvania Fact Sheet*, In Our Own Voice, https://blackwomen.vote/wp-content/uploads/2018/09/Voices_Fact_Sheet_PA.pdf. National figures illuminate one of the reasons why: "less than one-third of black working mothers are eligible for and can afford unpaid leave through the Family Medical Leave Act." Jamila Taylor, et al, *Eliminating Racial Disparities in Maternal and Infant Mortality: A Comprehensive Policy Blueprint,* Center for American Progress 65 (May 2, 2019), https://cdn.americanprogress.org/content/uploads/2019/04/30133000/Maternal-

Infant-Mortality-report.pdf. Without access to paid leave, Black women with caregiving responsibilities spend approximately 41% of their annual incomes on caregiving expenses, while white men and women with caregiving responsibilities spend just 14% of their annual incomes on such expenses. *Id*.

Black and multiracial women have the highest labor force participation rate; however, at all educational levels, Black women are concentrated in comparatively lower-paying jobs. *See* Asha DuMonthier et al., *The Status of Black Women in the United States: Executive Summary* ix (2017), http://statusofwomendata.org/wp-content/uploads/2017/06/SOBW_ExecutiveSummary_Digital-2.pdf. Regardless of the job they hold, pay inequity for Black women is stark; as of 2014, Black women who worked full-time, year-round earned only 64 cents for every dollar earned by white men in comparable roles. *Id.*

Black women's economic insecurity in Pennsylvania is at least as prevalent. Philadelphia is the most impoverished among the ten largest cities in the U.S. The Pew Charitable Trusts, *Philadelphia 2021: The State of the City* 8 (2021) https://www.pewtrusts.org/-/media/assets/2021/04/philadelphia-2021-state-of-the-city.pdf. Nearly half of all low-income Philadelphians live in deep poverty (meaning incomes less than half the poverty level). *Id.* Black Philadelphians account for approximately half of Philadelphia's low-income residents. *Id.* And among 44 metro areas with populations of at least 100,000 Black women, Pittsburgh ranked third to

last in Black women's economic outcome. Notably, it ranked *last* in health outcomes for Black women. *See* Brentin Mock, *What 'Livability' Looks Like for Black Women*, City Lab (Jan. 9, 2020), https://www.citylab.com/equity/2020/01/best-cities-black-women/604384/.

But it is not only pay inequity that disadvantages Black women. Wealth, or net worth, is also critical to economic security. *See* Insight Center for Community Economic Development, *Lifting as We Climb: Women of Color, Wealth, and America's Future* (Spring 2010), http://ww1.insightcced.org/uploads/CRWG/LiftingAsWeClimb-WomenWealth-Report-InsightCenter-Spring2010.pdf. Without assets that outweigh debt, a family may be one paycheck – or one health care crisis – away from poverty. *Id*., p. 5. While the median wealth for single white women ages 18-64 in 2007 was $41,500, the median wealth for single Black women in that same age range was only $100. *Id*., p. 7. Nearly half of single Black women had negative wealth. *Id*., p. 8. This is because "half of all single [B]lack and Hispanic women could not afford to take an unpaid sick day or to even have a major appliance repaired without going into debt." *Id*. For Black women facing such tight economic margins, the Coverage Ban may make abortion care entirely out of reach, or economically devastating to obtain.

C. Black LGBTQ-GNC people are also disparately likely to live in poverty.

Lesbian, gay, bisexual, transgender, queer, and gender non-conforming (LGBTQ-GNC) people are more likely to live in poverty than heterosexual and cisgender people. M.V. Lee Badgett et al., Williams Inst., *LGBT Poverty in the United States* 2 (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf; *see also* Jennifer Russomanno et al., *Food Insecurity Among Transgender and Gender Non-conforming Individuals in the Southeast United States: A Qualitative Study*, 4 Transgender Health 89 (2019). The disproportionality of poverty is even more drastic among bisexual women and transgender individuals, whose poverty rate of 29.4% is nearly double that of the general population. Badgett et al., *supra*, p. 2.; Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 144 (2016), http://www.ustranssurvey.org/reports. Racial disparities are present as well: Black people in same-sex couples are at least six times more likely than white men in same-sex couples and two times more likely than Black people in different-sex marriages to have low incomes. M.V. Lee Badgett et al., Williams Inst., *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community* 3 (2013), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Poverty-LGB-Jun-2013.pdf.

Unintended pregnancy is more common among bisexual women than it is among heterosexual women. Bethany G. Everett et al., *Sexual Orientation Disparities in Mistimed and Unwanted Pregnancy Among Adult Women*, 49 Perspectives on Sexual & Repro. Health 157, 161 (2017). It is reasonable to presume that bisexual women end unintended pregnancies at a rate consistent with the national average. Caroline S. Hartnett et al., *Congruence across Sexual Orientation Dimensions and Risk for Unintended Pregnancy Among Adult U.S. Women*, Women's Health Issues (2016). And, because an estimated 1.2 million LGBTQ adults are enrolled in Medicaid, Kerith J. Conron & Shoshana K. Goldberg, *LGBT Adults with Medicaid Insurance*, Williams Inst. 1 (Jan. 2018), it follows that LGBTQ-GNC enrollees – including Black women, girls, transgender, and GNC people – will need Medicaid coverage for abortion care.

D. People living in poverty – including Black women and girls – are more likely to need abortion care.

The Coverage Ban is particularly pernicious, as the people denied care are those facing the worst health outcomes. A national review of individuals seeking financial assistance[5] for abortion care in the absence of Medicaid or other forms of

[5] Non-profit organizations provide financial assistance to low-income people seeking abortion care. *See generally* Declaration of Elicia Gonzales (Jan. 19, 2019), *Allegheny Reproductive Health Center et al. v. Pennsylvania Department of Human Services et al.,* 26 M.D. 2019 (Pa. Cmwlth.) ("Declaration of Elicia Gonzales"). Each year, in Southeastern Pennsylvania alone, approximately 6,300 people need assistance paying for abortion care because of the Coverage Ban. *See* Women's Medical Fund, *People Who Cannot Afford an Abortion in Southeastern Pennsylvania: A Needs*

coverage revealed that the majority were Black women. J. Kotting & G.E. Ely, *The Undue Burden of Paying for Abortion: An Examination of Abortion Fund Cases* 2 (2017), https://abortionfunds.org/cms/assets/uploads/2017/08/Tiller-Fund-Report-2017-National-Network-of-Abortion-Funds.pdf. In Southeastern Pennsylvania, a staggering 85% of people seeking financial assistance for abortion care in 2020 identified as Black or Latinx; of those, more than half were living in deep poverty. Women's Medical Fund, *Impact*, https://www.womensmedicalfund.org/impact (last visited September 29, 2021). Absent the Coverage Ban, the majority seeking funding support – 63%– would have had coverage for abortion care. *Id.*

Yet, those with the least access to abortion care are most likely to need it. *See generally* WMF Needs Assessment, *supra*. Three-fourths of all abortion patients in 2014 were low-income, and people with incomes less than 100% of the federal poverty level accounted for almost half of all abortion patients. Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. J. of Pub. Health 1904 (Dec. 2017).

Lower income is correlated with unintended pregnancy. In 2011, the rate of unintended pregnancy among women with incomes less than 100% of the poverty level was more than five times that of women with incomes at or above 200% of the poverty level. Guttmacher Institute, *Unintended Pregnancy in the United States* (Jan.

Assessment (2019), https://www.womensmedicalfund.org/resources (hereinafter "WMF Needs Assessment").

2019), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states; Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States*, 2008–2011, 374 New Eng. J. Med. 843 (2016). This correlation is not surprising, since Medicaid beneficiaries, who are by definition low-income, are more likely to experience gaps in contraception use that put them at higher risk of unintended pregnancy than those with other insurance. Jennifer J. Frost et al*., supra*.

IV. THE IMPORTANCE OF MEDICAID COVERAGE OF ABORTION CARE FOR BLACK WOMEN AND GIRLS.

Having a lower income makes it more challenging to raise a child. Approximately 73% of respondents in a national survey indicated that they sought abortion care because they could not afford to have a child. Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Perspectives on Sexual & Repro. Health 110 (2005). Most people who seek abortion care are already parents; almost 60% are parenting at least one child, and one-third have two or more children. *See* Jones et al., *supra, Characteristics of U.S. Abortion Patients*. Yet, the same financial constraints that increase the need for abortion care also make it harder to access it – necessitating Medicaid coverage of abortion care.

As explained above, the long history of race and gender discrimination and structural barriers affecting Black women and girls means that they are overrepresented in low-wage jobs, more vulnerable to job loss in economic

downturns, and, therefore, more likely to be Medicaid-eligible. *See e.g.*, National Partnership for Women & Families and In Our Own Voice: National Black Women's Reproductive Justice Agenda, *Issue Brief: Maternal Health and Abortion Restrictions: How Lack of Access to Quality Care is Harming Black Women* 4 (October 2019), https://www.nationalpartnership.org/our-work/resources/repro/maternal-health-and-abortion.pdf. Thus, Black women needing abortion care in Pennsylvania are particularly affected by the Coverage Ban.

A. Out-of-pocket costs for abortion services are prohibitively high for people living with low-incomes.

In 2014, the mean cost of an abortion at 10 weeks of pregnancy was $500, and $1,195 at 20 weeks. Guttmacher Institute, *Medicaid Funding of Abortion* (Jan. 2020), https://www.guttmacher.org/evidence-you-can-use/medicaid-funding-abortion. The cost of abortion care in Pennsylvania reaches upwards of $3,500. *See* Declaration of Elicia Gonzales.

These are not expenses that people can simply absorb. More than half of respondents to a national survey reported that out-of-pocket costs for abortion represented more than one-third of their monthly income. Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues 211 (2014). Many people do not have the resources to handle an emergency expense of this magnitude – a 2016 national survey found that over 40% of adults said they could not cover an emergency expense of $400, or

would cover it by selling something or borrowing money. *See* Board of Governors of the Federal Reserve System, *Report on the Economic Well-Being of U.S. Households in 2016* (May 2017), https://www.federalreserve.gov/publications/files/2016-report-economic-well-being-us-households-201705.pdf. As noted, more than half of single Black women have negative wealth and could not absorb such an emergency expense, or would be forced into debt to do so.

Moreover, the out-of-pocket costs for abortion services do not include the costs of obtaining that care, including travel, overnight stays, and childcare. *See* Terri-Ann Thompson & Laura Fix, All* Above All and Ibis Reproductive Health, *Research Brief: The Impact of Out-of-pocket Costs on Abortion Care Access* (Sept. 2016), https://www.ibisreproductivehealth.org/publications/research-brief-impact-out-pocket-costsabortion-care-access. For many Pennsylvanians, these added costs are unavoidable: approximately 85% of Pennsylvania counties lack a clinic that provides abortion services, substantially increasing the financial burden for people who need to travel to seek abortion care. *See* Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Institute (2019), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf. Nearly half the women in Pennsylvania live in counties with no abortion clinic. *Id*.

B. Delay in abortion care may increase costs and risks.

People living with low-incomes are often forced to carry unwanted pregnancies longer while they attempt to obtain funds for abortion care. *See* Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions*, 12 PLoS One (2017). To raise necessary funds, people experiencing economic insecurity, who in Pennsylvania and throughout the U.S. are disproportionately Black women and girls, see *Issue Brief: Maternal Health and Abortion Restrictions: How Lack of Access to Quality Care is Harming Black Women, supra* at 5, must often forego necessities, sell possessions, or obtain exploitative payday loans. *See* Amanda Dennis et al., *Does Medicaid Coverage Matter? A Qualitative Multi-State Study of Abortion Affordability for Low-income Women*, 25 J. Health Care for the Poor and Underserved 1571 (2014). Yet even when they make those sacrifices, low-income Pennsylvanians may *still* be unable to cover the full cost of abortion care. *See generally* Declaration of Elicia Gonzales.

Those who eventually raise the funds may end up paying *more* for abortion care because of delays necessitated by costs and travel. It is expensive to be poor. Approximately 11.3% of people who have abortions do so after 13 weeks gestation because of these costs. *See* WMF Needs Assessment. In Southeastern Pennsylvania alone that means that *at least* 718 people each year must wait until the second

trimester for abortion care due to difficulty obtaining funds. *Id.* Low-income women – as explained above, disproportionately Black women and girls – may be forced to go three weeks longer to obtain an abortion than those with abortion coverage, even though 67% of low-income women seeking abortion care report that they would have preferred to have the service earlier. *Id.* The challenge of obtaining funds for abortion care means that people are later in pregnancy when they finally have the money, but the later in pregnancy, the higher the cost of abortion care itself. *Id.* Those costs include health risks: while risks of later abortion are very low, they are higher than abortions provided during the first trimester. *See* Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126 Obstet. & Gynecol. 258 (2015).

The longer the delay, the more likely a person will have to forego an abortion and carry a pregnancy to term. Nationally, over 4,000 pregnant people each year are unable to obtain abortion care before they reach gestational limits. Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687 (2014). The most common reason for being unable to obtain care in time was the cost associated with the procedure and travel. *Id.* Pennsylvania generally does not permit abortions after 24 weeks, so pregnant people who have to delay abortion to gather funds are likely to be denied outright after that point. *See* Guttmacher Institute, *State Bans on Abortion*

Throughout Pregnancy (Apr. 1, 2020), https://www.guttmacher.org/print/state-policy/explore/state-policies-later-abortions

C. Having to forego abortion care has significant harmful consequences.

As shown, Black women and girls face structural inequities that, until they are redressed, increase their vulnerability to economic and health disparities. The very disparities that make them more likely to need Medicaid coverage and to lack funds to pay out-of-pocket for abortion care are the same disparities that increase the likelihood of unintended pregnancy and the need for abortion care. Not getting a needed abortion can make these disparities – from increased economic insecurity to adverse health outcomes – worse.

For people living in poverty – disproportionately Black women and girls – not getting the abortion they need increases their risk of remaining in long-term poverty. One study demonstrated that women who sought but were unable to obtain abortion care were almost four times more likely to live below the federal poverty line than women who received abortion care – a difference that persisted over four years. Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407 (2018). This is unsurprising, because getting needed abortion care enables people to achieve significant life goals related to education, employment, and relocation. *Id.; see also* Ushma D. Upadhyay et al., *The Effect of Abortion on*

Having and Achieving Aspirational One-Year Plans, 15 BMC Women's Health 102 (Nov. 2015).

Ongoing poverty is not the only risk. The risk of death associated with carrying a pregnancy to term is 14 times higher than the risk of an abortion. *See* Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215 (2012). These statistics do not take into account that Black women and girls disproportionately die or experience serious complications in pregnancy, as discussed above.

For all people, including Black women and girls, who are experiencing IPV, policies like the Coverage Ban heighten vulnerability to abuse. *See* Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 1 (Sept. 2014), https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-014-0144-z. Pregnant women experience high rates of intimate partner violence that is often severe, frequently resulting in serious injuries. Beth A. Bailey, *Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management*, 2 Int'l J. Women's Health 183 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2971723/. Homicide may also be a risk: Black women and very young women are most likely to be murdered during

pregnancy. Jeani Chang et al., *Homicide: A Leading Cause of Injury Deaths Among Pregnant and Postpartum Women in the United States, 1991-1999*, 95 Am. J. Pub. Health 471, 473 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449204.

Further, survivors of IPV may be trapped in violent relationships if they cannot access abortion care when they seek it. *See* Roberts, *Risk of Violence* (between six and 22 percent of abortion patients report recent violence from an intimate partner). For people in abusive relationships who sought abortion care but were denied, having a baby with the abuser resulted in ongoing violence, measured over the course of two and one-half years post-pregnancy. *Id*. Conversely, "having an abortion was associated in a reduction over time in physical violence" from the abuser involved in the pregnancy. *Id.*

In short, the Coverage Ban exposes people needing abortion care – especially Black women and girls – to additional serious harms.

V. THE COVID-19 PANDEMIC HAS HIGHLIGHTED AND WORSENED RACIAL AND ECONOMIC DISPARITIES, WHILE INCREASING BOTH THE NEED FOR ABORTION CARE AND THE CHALLENGES OF ACCESSING IT.

The COVID-19 pandemic has highlighted racial healthcare disparities and the importance of publicly-funded health care. It has also increased the likelihood that people will need abortion care and the challenges of obtaining that care.

A. COVID-19 has dramatically increased economic insecurity.

Unemployment rates skyrocketed as the pandemic spread across the U.S. Patricia Cohen, New York Times, *Jobless Numbers Are 'Eye-Watering' but Understate the Crisis* (Apr. 23, 2020), https://www.nytimes.com/2020/04/23/business/economy/unemployment-claims-coronavirus.html. Pennsylvania saw one of the largest percentages of job cuts, with one in six workers losing their jobs at the outset of the pandemic. *See* Nigel Chiwaya and Jiachuan Wu, *The Coronavirus has Destroyed the Job Market in Every State,* https://www.nbcnews.com/business/economy/unemployment-claims-state-see-how-covid-19-has-destroyed-job-n1183686 (Apr. 14, 2020). At the end of 2020, unemployment rates were higher for Black workers in Pennsylvania than in other states. *See* State Unemployment by Race and Ethnicity, 2020 Q3 & Q4, Economic Policy Institute, https://www.epi.org/indicators/state-unemployment-race-ethnicity-2020q3q4/.

Low-wage workers are especially vulnerable. In 2020, 80% of job losses were among the lowest quarter of wage earners. Elise Gould and Melat Kassa, Economic Policy Institute, *Low Wage, Low Hours Workers Were Hit Hardest In the COVID-19 Recession* (May 20, 2021). According to one report, between February 2020 and February 2021, employment losses were largest in the leisure and hospitality industry, where Black women, Latinx women, and Asian Americans and Pacific

Islanders experienced disproportionate losses because of occupational segregation (*i.e.* these workers are less likely to be in higher-paid management positions and therefore experienced the worst of the job losses). *Id* And low-wage jobs have been the slowest to return to pre-COVID-19 levels. *See* Nicole Bateman and Martha Ross, Brookings Institute, *The Pandemic Hurt Low Wage Workers The Most—and So Far, The Recovery Has Helped Them the Least* (July 28, 2021).

For low-wage workers still employed throughout the pandemic, many have jobs that put them put them at risk of exposure to COVID-19. Black women are overrepresented in jobs such as nursing assistants, registered nurses, and personal care aides, "where workers are more likely to stay employed through the health crisis" but more likely to be exposed to COVID-19. Holder et al., *supra* at 13.

The risks these workers face are compounded by lack of paid sick leave, childcare responsibilities, and reliance on public transportation. *See, e.g.,* Elise Gould, Economic Policy Institute, *Amid Covid-19 Outbreak, the Workers who Need Paid Sick Days the Most Have the Least* (Mar. 9, 2020), https://www.epi.org/blog/amid-covid-19-outbreak-the-workers-who-need-paid-sick-days-the-most-have-the-least/. Pennsylvanians have no statewide sick leave protections. *See* Pennsylvania Department of Labor and Industry, *General Wage and Hour Questions*, https://www.dli.pa.gov/Individuals/Labor-Management-Relations/llc/Pages/Wage-FAQs.aspx.

B. COVID-19 exposes and exacerbates health disparities.

Not only are women of color more likely to work in low-wage jobs directly affected by COVID-19, people of color have borne the highest caseloads and worse mortality from COVID-19, the result of disparities rooted in structural and systemic racism, economic inequality, and depletion of resources for publicly funded health centers. *See* Jessica Mason & Paula Molina Acosta, National Partnership for Women & Families, *Called to Care: A Racially Just Recovery Demands Paid Family and Medical Leave* (March 2021), https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/called-to-care-a-racially-just-recovery-demands-paid-family-and-medical-leave.pdf (citing APM Research Lab, *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.*, (March 2 2021) https://www.apmresearchlab.org/covid/deaths-by-race). For Black women and girls who are immigrants, accessing health care remains a risk: immigrants report that they are reluctant to seek testing or virus-related care out of fear of immigration consequences. *See* Miriam Jordan, New York Times, *We're Petrified: Immigrants Afraid to Seek Medical Care for Coronavirus* (Apr. 10, 2020), https://www.nytimes.com/2020/03/18/us/coronavirus-immigrants.html. For survivors of IPV, including Black women and girls, the pandemic has brought added risks – following the institution of stay-at-home orders, IPV increased worldwide. *See, e.g.*, Amanda Taub, *A New Covid-19 Crisis: Domestic Abuse Rises Worldwide*,

New York Times (Apr. 2020), https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html.

C. Access to coverage for abortion care is critical during COVID-19.

The financial strain caused by the COVID-19 pandemic has particularly harmed women of color. More than 7 in 10 women of color have been negatively impacted by COVID-19, including suffering the death of a family member, having difficulty paying bills, or experiencing the loss of a job. In Our Own Voice, et al., *Intersections of our Lives: Poll Summary* 3 (2021), https://intersectionsofourlives.org/wp-content/uploads/2021/07/ISOOL_Fact-Sheet-Poll-Summary-final.pdf. As a result of this unprecedented job loss, Medicaid enrollment has increased. *See generally* Bradley Corallo and Avirut Mehta, Kaiser Family Foundation, *Analysis of Recent National Trends in Medicaid and CHIP Enrollment* (Sept. 21, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/.

The COVID-19 pandemic has further worsened structural inequities for people of color in particular, undermining their access to contraception. *See* Nadia Diamond-Smith *et al.,* Contraception, *COVID-19's Impact on Contraception Experiences: Exacerbation of Structural Inequities in Women's Health* (Aug. 26, 2021), https://www.contraceptionjournal.org/article/S0010-7824(21)00369-

3/fulltext. Thus, even for people with health coverage, COVID-19 has made it harder to get contraceptive care, increasing the likelihood of unintended pregnancies.

In short, the pandemic has exacerbated the need for abortion care and the challenges of paying out-of-pocket for this care and attendant costs. Preventing Black women and girls in Pennsylvania who need abortions from getting this care undermines public health at any time; maintaining the Coverage Ban now, during a global pandemic, is unconscionable.

CONCLUSION

The Coverage Ban violates the Pennsylvania Constitution, and particularly harms Black women and girls. Accordingly, *Amici* urge this Court to hold that the Coverage Ban violates the Pennsylvania Constitution's guarantees of equality.

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CERTIFICATE OF WORD COUNT

I certify that this Brief contains 6,987 words, counted by the word-counting feature of the wordprocessing system used to prepare this brief, exclusive of case captions, cover page, tables, signature blocks, certifications, and the appendix.

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CERTIFICATE OF COMPLIANCE WITH RULE 127

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

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APPENDIX A

INDIVIDUAL STATEMENTS OF *AMICI CURIAE* ORGANIZATIONS

New Voices for Reproductive Justice

New Voices for Reproductive Justice ("New Voices") is a Pennsylvania non-profit organization that works through leadership development, community organizing, policy advocacy, and culture change to amplify the voices of Black women and girls, who demand and deserve access to quality and culturally responsive health care. New Voices was instrumental in the passage of the Affordable Care Act, its implementation in Pennsylvania, and the expansion of Medicaid in Pennsylvania.

New Voices and all *amici* share the goal that Black women and girls live long, healthy, and joyful lives – goals that are impeded when Medicaid restrictions relegate Black women and girls to second-class citizenship in health care.

In Our Own Voice: National Black Women's Reproductive Justice Agenda

In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national-state partnership focused on lifting up the voices of Black women, femmes, girls and gender expansive people at the national, state and regional levels in the ongoing policy fight to secure Reproductive Justice for all.

Black Feminist Future

Black Feminist Future (BFF) is a political hub focused on the dynamic possibilities of galvanizing the social and political power of Black women, girls, and gender-

expansive people towards liberation. We do this by building and nourishing the leadership of fierce Black feminists, fortifying aligned organizations and movements, and shifting cultural norms. BFF envisions a world where all Black women, girls, and gender-expansive folks are: safe, joyful, cared for, powerful, self-determining, and thriving. We envision a world where freedom is our birthright and we are in abundant, nurturing, and interdependent relationships with our communities and the earth.

Black Girl's Guide to Surviving Menopause

The Black Girl's Guide to Surviving Menopause is a multimedia project seeking to curate and share the experiences, stories, and realities of non-binary, Black women, and femmes over 50 related to aging, intimacy, body, spirituality and change through the medium of audio storytelling. We've hosted sold out events in Washington, DC and Durham, NC in addition to an international conference in Kenya. We are creating spaces for non-binary, Black women, and femmes to have intentional, intergenerational conversations around life, intimacy, pleasure, and vulnerability.

Black Mothers in Power

Black Mothers in Power is a Delaware organization that seeks to eradicate racial health disparities for Black birthing people and Black babies throughout Delaware. We launched our Community Based Doula Training Program in 2021, and continue to provide immediate relief to families in need during the pandemic, and network

with Black women and allies across Delaware. Black Mothers in Power envisions a state where all Black birthing people are informed about their birthing rights, have autonomy over their reproductive decision, and are treated equitably in the healthcare system.

Black Women for Wellness

Black Women for Wellness is a reproductive justice (RJ) organization committed to the health and wellbeing of Black women and girls. In alignment with our RJ values, we understand that abortion care is healthcare and as such, those who are in need of and utilize public insurance, should have this very vital healthcare service covered. Every person should be able to have an abortion if they so choose -- regardless of economic status -- because they have the right to determine if, when and how to parent and have a family. Black women are disproportionately precluded from exercising this right, because of their overrepresentation in Medicaid coverage rates.

Dignity Act Now Collective

The Dignity Act Now Collective is a Pennsylvania organization that works to advocate for impacted individuals while uplifting their experiences through political education and artivism (art activism). We show up as experts of our own experiences utilizing the arts to create, promote, and instigate systemic change. We are a force for transformational change that empowers impacted people to aspire to their highest selves. The Collective has worked with local legislators in both Philadelphia and

Pittsburgh to craft policies including alternative sentencing for pregnant women and requiring trauma-informed care for women living in the Pennsylvania prison system.

Feminist Women's Health Center

Feminist Women's Health Center (FWHC) is a Black-led, independent, non-profit, multi-generational, multi-racial reproductive health, rights, and justice organization committed to a vision of accessible and judgment-free reproductive health care and abortion access in the South for all who need it. Founded in 1976 in Atlanta, GA, FWHC offers compassionate abortion care as part of comprehensive reproductive health services and works to improve access for traditionally underserved communities. Using an intersectional reproductive justice approach, Feminist Center's services and programs aim to meet the unique needs of people of color, low-income, Spanish-speaking, immigrant, refugee, and LGBTQIA+ clients. More than a health care provider, Feminist Center has been an advocacy leader at the state policy level, and at the national level through coalitions and partnerships, for the past two decades, defending against any attacks on reproductive rights and advancing proactive policy to achieve reproductive justice.

Gwen's Girls and the Black Girls Equity Alliance

Promoting and advocating for the health and well-being of Black women and girls is essential to the mission of Gwen's Girls. Gwen's Girls is a non-profit organization

based in Pittsburgh. Our vision is one of girls becoming self-sufficient adults, equipped with the capacity to continuously evolve emotionally, physically, and spiritually; build strong family units; develop a strong support system; and contribute to community life. We agree that all women and girls should have a full range of access to healthcare and Medicaid is the predominant source of healthcare for Black people in Pennsylvania.

Let's Get Free: The Women & Trans Prisoner Defense Committee

Let's Get Free: The Women and Trans Prisoner Defense Committee is a Pennsylvania group that educates and organizes around issues of prison injustice, addressing policies, contributing factors and collateral consequences of mass incarceration, as well as envisioning new systems of transformative justice and healing. We prioritize the experiences of women and trans prisoners. We believe that abortion is health care.

Life House Lactation and Perinatal Services, LLC

Life House Lactation & Perinatal Services, LLC, founded by Jabina G. Coleman, has served women, children, and families throughout the Philadelphia region for over a decade. Jabina engages with communities through her work as the owner of where she provides lactation consultation services and reproductive psychotherapy with a focus on perinatal mental health. She is also the co-founder and president of Perinatal Mental Health Alliance for People of Color, unifying professionals of color

to support communities' perinatal mental health needs. Additionally, Jabina is the co-founder of Breastfeeding Awareness & Empowerment, a grassroots organization created in response to the public outcry surrounding adverse perinatal health outcomes for U.S. Black families.

Monica McLemore, PhD, MPH, RN, FAAN

Monica McLemore is an Associate Professor and the Thelma Shobe Endowed Professor of Ethics and Social Justice at the University of California-San Francisco's Department of Family Health Care Nursing, and a Clinician-Scientist at Advancing New Standards in Reproductive Health (ANSIRH). I am also an expert nurse in the provision of sexual and reproductive healthcare services. My skills include patient education and counseling, provision of contraception and nursing support of first trimester (medication, aspiration) and second trimester abortion services (D&E), ultrasound, cardiac monitoring, procedural sedation, symptom management, telephone triage, and emotional and physical support. I retired from active clinical practice as a public health and staff nurse after a 28-year career; however, I continue to provide flu and COVID-19 vaccinations and conduct clinically relevant research. I believe that public insurance coverage of abortion is essential to achieving health equity and reproductive justice by creating greater access to evidence-based reproductive health care.

National Asian Pacific American Women's Forum

The National Asian Pacific American Women's Forum (NAPAWF) is the leading national multi-issue community organizing and policy advocacy organization for Asian American and Pacific Islander (AAPI) women and girls in the United States. NAPAWF's mission is to build collective power of all AAPI women and girls to gain full agency over our lives, our families, and our communities. NAPAWF advocates and organizes with a reproductive justice framework that acknowledges the diversity within our community and ensures that different aspects of our identity – such as ethnicity, immigration status, education, sexual orientation, gender identity, and access to health – are considered in tandem when addressing our social, economic, and health needs. Our work includes advocating for the reproductive rights and health care needs of AAPI women and ensuring AAPI women's access to sexual and reproductive health care services.

National Birth Equity Collaborative

The National Birth Equity Collaborative (NBEC) is one of the nation's leading experts and an advocate for change in the Black maternal health and infant mortality crises. As an organization focused on the sexual reproductive health and wellbeing of Black women and birthing people world-wide, NBEC creates global solutions that optimize Black maternal, infant, sexual, and reproductive wellbeing.

We shift systems and culture through training, research, technical assistance, policy, advocacy, and community-centered collaboration.

Oshun Family Center

Oshun Family Center is a Pennsylvania non-profit organization, birthed from an experience by the founder, Saleemah J. McNeil. She suffered a traumatic birth in 2006 while delivering her son. From suffering severe preeclampsia to an emergency c-section, Saleemah has worked hard to recover from this experience. Our mission at Oshun Family Center is to fight the stigma of mental health by providing culturally sensitive services to women, children and families impacted by perinatal mood and anxiety disorders in minority communities. It is our vision to charge constituents, legislators, policy makers and stake holders to raise awareness and advocate for Black maternal health. Abortion care is maternal care – therefore it is our priority to support causes and legislation that understand the importance of being inclusive.

Philadelphia Chapter of NOW

The Philadelphia Chapter of the National Organization for Women (PhillyNOW) is a membership organization whose mission is economic justice, reproductive justice, gender equality, combatting racism, ending violence against women, and constitutional equality. PhillyNOW works toward a broad vision for progress for women, predicated on intersectionality and inclusion, and strives to secure abortion, birth control, and reproductive rights for all women.

Philadelphia Commission for Women

The Philadelphia Commission for Women was established by an amendment to the Philadelphia Home Rule Charter that was approved by voters in the May, 2015 Primary Election charged with promoting civic, educational and economic policies for women and providing advice and recommendations to the Mayor and City Council on policies and programs that advance equal rights and opportunities for women in the City of Philadelphia.

Reverend Deneen Robinson

Rev. Deneen Robinson is the Program Director at the Afiya Center in Dallas, Texas. The Afiya Center is the only Reproductive Justice organization in North Texas founded and directed by Black women. Its mission is to serve Black women and girls by transforming their relationship with their sexual and reproductive health through addressing the consequences of reproductive oppression. Deneen has been a leader in HIV and addiction activism for over 20 years. After receiving a degree in social work from the University of Texas in Austin, followed closely by her own diagnosis with HIV, Deneen found her calling ministering to those on the margins. She began her work at the Margaret Wright Clinic at South Dallas Health Access, now the Peabody Clinic, and the Legacy Founders Cottage. She founded At the Kitchen Table, a resource group for women in Dallas in 1999. Deneen has been featured in The Dallas Examiner Supplement on HIV, The Black AIDS Institute, Newsweek,

HIV Plus, the Dallas Voice, aidsmeds.com, and has consulted for the CDC, The Well Project, The Black AIDS Institute, and The International AIDS Society.

SisterLove, Inc.

SisterLove, Inc is an Atlanta-based sexual and reproductive justice advocacy organization dedicated to eradicating the impact of HIV, AIDS, and reproductive oppression upon all women and girls of color, including both transgender and cisgender women and girls, and their families. We join this brief because access to abortion is a major tenet of our organization. The women that we advocate for are often lower-income, Black and Indigenous People of Color (BIPOC), and living with HIV/AIDS and they, as some of the most marginalized in our society, rely on federal and state healthcare funding for their healthcare needs. A person relying on federal or state healthcare who needs an abortion may be forced to carry their pregnancy to term due to Pennsylvania's failure to cover abortion care in its Medicaid program. This is unacceptable.

SisterReach

SisterReach, founded in 2011, is a Memphis, Tennessee based grassroots non-profit supporting the reproductive autonomy of women and teens of color, poor and rural women, LGBT+ and GNC folx, and their families through the framework of Reproductive Justice. Our mission is to empower our base to lead healthy lives, raise healthy families and live in healthy and sustainable communities. We work from a

four-pronged strategy of education, policy and advocacy, culture shift, and harm reduction.

SPARK Reproductive Justice NOW!, Inc.

SPARK envisions a world free from economic, social, political, cultural and sexual oppression – especially anti-Black oppression; where Black queer women and young people, including trans folx and folx living outside the gender binary have access to rest and thrive. We seek to bring about a world wherein communities center and hold each other's humanity with love, grace, joy, healing, and accountability. We imagine a future where marginalized people have the autonomy to make decisions about their lives, bodies, sexuality, and reproduction free from fear, stigma and shame. We envision a world where our people get to be their and their ancestors' wildest dreams.

The Womanist Working Collective

Established in 2015, the Womanist Working Collective is a social action and support collective for Black womyn (both cis & trans), femmes, and gender non-conforming folks, based in Philadelphia. Our Community of Practice unapologetically centers the Quality of Life and livelihoods for Black womyn, transwomen, femmes and gender variant folks through Community Organizing, Philanthropy and Self-care. When low-income Black women, femmes and gender non-conforming and non-binary folx cannot access abortions, it keeps them and their families in cycles of

poverty impacting both their quality of life and ability to maintain their basic needs. Not covering abortions for Medicaid patients has a snowball effect, as it impacts the economic security of our communities which are already experiencing compounding structural inequalities.

Women With A Vision, Inc.

Women With A Vision, Inc (WWAV) is a community-based nonprofit in New Orleans, Louisiana, founded in 1989 by a grassroots collective of African-American women in response to the spread of HIV/AIDS in communities of color. The mission of WWAV is to improve the lives of marginalized women, their families, and communities by addressing the social conditions that hinder their health and well-being. We accomplish this through relentless advocacy, health education, supportive services, and community-based participatory research.

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CERTIFICATE OF SERVICE

I certify that on October 13, 2021, I caused a copy of the foregoing to be served on the following via PACFile and/or by First Class Mail, which satisfies Pennsylvania Rule of Appellate Procedure 121:

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