NO. 18-2133

United States Court of Appeals

for the

Fourth Circuit

PLANNED PARENTHOOD SOUTH ATLANTIC; JULIE EDWARDS,
on her behalf and on behalf of all others similarly situated,

Plaintiffs-Appellees,

– v. –

JOSHUA BAKER, in his official capacity as Director,
South Carolina Department of Health and Human Services,

Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA (COLUMBIA)
DISTRICT COURT CASE NO. 3:18-CV-02078-MGL
MARY G. LEWIS, U. S. DISTRICT COURT JUDGE

BRIEF OF REPRODUCTIVE RIGHTS AND JUSTICE ORGANIZATIONS AND ALLIED ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

JANE LIU
MARIAH LINDSAY
NATIONAL ASIAN PACIFIC
AMERICAN WOMEN'S FORUM
(NAPAWF)
1730 Rhode Island Avenue, NW,
Suite 210
Washington, DC 20036
(773) 251-8440
jliu@napawf.org

JULIE RIKELMAN
Counsel of Record
PILAR HERRERO
AMY MYRICK
CAROLINA VAN DER MENSBRUGGHE
CENTER FOR REPRODUCTIVE RIGHTS (CRR)
199 Water Street, 22nd Floor
New York, New York 10038
(917) 637-3600
jrikelman@reprorights.org

Attorneys for Amici Curiae
(Amici appreciate the assistance of Bethany Van Kampen and Nina Serrianne (National Latina Institute for Reproductive Health), Natasha Chabria and Jessica Pinckney (In Our Own Voice) and Fran Linkin (Center for Reproductive Rights) in the preparation of this brief)

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT
DISCLOSURE OF CORPORATE AFFILIATIONS AND OTHER INTERESTS

Disclosures must be filed on behalf of all parties to a civil, agency, bankruptcy or mandamus case, except that a disclosure statement is **not** required from the United States, from an indigent party, or from a state or local government in a pro se case. In mandamus cases arising from a civil or bankruptcy action, all parties to the action in the district court are considered parties to the mandamus case.

Corporate defendants in a criminal or post-conviction case and corporate amici curiae are required to file disclosure statements.

If counsel is not a registered ECF filer and does not intend to file documents other than the required disclosure statement, counsel may file the disclosure statement in paper rather than electronic form. Counsel has a continuing duty to update this information.

No. 18-2133 Caption: Planned Parenthood South Atlantic; Julie Edwards v. Baker

Pursuant to FRAP 26.1 and Local Rule 26.1,

Access Reproductive Care - Southeast
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

2. Does party/amicus have any parent corporations? ☐ YES ☑ NO
If yes, identify all parent corporations, including all generations of parent corporations:

3. Is 10% or more of the stock of a party/amicus owned by a publicly held corporation or other publicly held entity? ☐ YES ☑ NO
If yes, identify all such owners:

4. Is there any other publicly held corporation or other publicly held entity that has a direct financial interest in the outcome of the litigation (Local Rule 26.1(a)(2)(B))? ☐ YES ☑ NO
If yes, identify entity and nature of interest:

5. Is party a trade association? (amici curiae do not complete this question) ☐ YES ☐ NO
If yes, identify any publicly held member whose stock or equity value could be affected substantially by the outcome of the proceeding or whose claims the trade association is pursuing in a representative capacity, or state that there is no such member:

6. Does this case arise out of a bankruptcy proceeding? ☐ YES ☑ NO
If yes, identify any trustee and the members of any creditors' committee:

Signature: /s/ Julie Rikelman Date: 1/22/19

Counsel for: Access Reproductive Care - SE

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I certify that on 1/22/19 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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No. 18-2133 Caption: Planned Parenthood South Atlantic; Julie Edwards v. Baker

Pursuant to FRAP 26.1 and Local Rule 26.1,

Center for Reproductive Rights
(name of party/amicus)

who is amicus, makes the following disclosure:
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Counsel for: Center for Reproductive Rights

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No. 18-2133 Caption: Planned Parenthood South Atlantic; Julie Edwards v. Baker

Pursuant to FRAP 26.1 and Local Rule 26.1,

In Our Own Voice: National Black Women's Reproductive Justice Agenda
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

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Signature: /s/ Julie Rikelman Date: 1/22/19

Counsel for: In Our Own Voice

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No. 18-2133 Caption: Planned Parenthood South Atlantic; Julie Edwards v. Baker

Pursuant to FRAP 26.1 and Local Rule 26.1,

National Latina Institute for Reproductive Health (NLIRH)
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

1. Is party/amicus a publicly held corporation or other publicly held entity? ☐ YES ☑ NO

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Signature: /s/ Julie Rikelman Date: 1/22/19

Counsel for: NLIRH

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Pursuant to FRAP 26.1 and Local Rule 26.1,

National Asian Pacific American Women's Forum ("NAPAWF")
(name of party/amicus)

who is amicus, makes the following disclosure:
(appellant/appellee/petitioner/respondent/amicus/intervenor)

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Signature: /s/ Julie Rikelman Date: 1/22/19

Counsel for: NAPAWF

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No. 18-2133 Caption: Planned Parenthood South Atlantic; Julie Edwards v. Baker

Pursuant to FRAP 26.1 and Local Rule 26.1,

Women's Rights and Empowerment Network (WREN)
(name of party/amicus)

who is amicus, makes the following disclosure:
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Counsel for: WREN

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INTEREST OF *AMICI CURIAE*

Amici are six reproductive rights, health, and justice organizations and allies. "Reproductive justice" refers to a movement, a mission, and a theoretical framework rooted in the belief that all individuals and communities should have the economic, social, and political power and resources to define and make decisions about their bodies, health, sexuality, families, and communities in all areas of their lives with dignity and self-determination. Black women in the United States founded the reproductive justice movement, community, and framework in the 1990s in direct response to ongoing human rights abuses. Reproductive justice is the human right to maintain personal bodily autonomy, have children, not have children, and parent the children one has in safe and sustainable communities. As a framework, reproductive justice centers women of color, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, while focusing attention on the social, political, and economic conditions that inhibit or enable people to exercise their human rights to decide if, when, and how to parent, free from discrimination. The reproductive justice framework incorporates an intersectional, social justice lens to dismantle inequalities at the root of reproductive oppression. The framework contextualizes human rights standards in the United States and analyzes the ways in which laws, policies, and systems inhibit health and equity. Because *Amici* believe that all people should have the power to make decisions regarding their own bodies and access the health care

they need, *Amici* have an interest in this case. *Amici* respectfully urge the Court to reject Appellants-Defendants' arguments and affirm the district court's ruling.

A full list of signers appears in the Addendum.[1]

INTRODUCTION

At the heart of reproductive justice is the principle that all individuals and communities should have the ability to make their own decisions about their bodies, families, and lives. For women of color,[2] intersecting historical, economic, cultural, social, and political conditions have limited their ability to make these decisions and exercise their human rights. The actions taken by South Carolina—and challenged in this case—illustrate this reality.

At issue is a South Carolina measure that would deny Medicaid beneficiaries their right to choose their own provider and bar them from accessing critical

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[1] No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *Amici*, their members, or their counsel made a monetary contribution to this brief's preparation or submission.

[2] This brief uses the term "women of color" to refer to women with diverse racial and ethnic identities whose communities have their own unique histories, as well as shared experiences of harm caused by racism and white supremacy. Although this brief uses the term "women," the denial of reproductive health care and related insurance coverage also affects gender non-binary people and transgender men. *Amici* acknowledge that women, transgender individuals, and gender non-binary individuals rely on Medicaid and use sexual and reproductive health care services, and that all these individuals may be harmed by South Carolina's actions. In this brief, *Amici* focus specifically on the harms to women of color that South Carolina's efforts to restrict rights will inflict.

reproductive health care services provided at Planned Parenthood. This measure poses serious risks to the health and agency of women of color, who make up a disproportionate number of Medicaid beneficiaries in South Carolina. For women of color, the right to seek care from the qualified and willing medical provider of their choice is critically important to their health, dignity and self-determination—particularly with respect to sexual and reproductive health care services. Further, Medicaid beneficiaries' ability to bring § 1983 actions to enforce their rights under the Medicaid statute ensures that women of color with Medicaid insurance have access to justice through the courts. If accepted, South Carolina's position could have far-reaching and potentially devastating consequences for women of color, their families, and their communities.

ARGUMENT

The Medicaid program has advanced reproductive justice in the United States by expanding access to health care through public insurance that millions of women of color rely upon to build healthy, self-determined lives and families. The "free choice of provider provision," and the access to providers of high-quality, comprehensive sexual and reproductive health care services that it facilitates, has made Medicaid a crucial resource for women of color with low incomes across the United States.

Congress created the Medicaid program in 1965 with a central goal of providing individuals with low incomes dignified health care in their communities, free from inappropriate government interference.[3] In 1967, noting that the law did not prevent states from limiting recipients' access to high quality providers—and concerned that Medicaid recipients were unable to visit the sources of medical care that they preferred—Congress added a provision to "assure that any individual eligible for medical assistance will be free to obtain such assistance from the qualified institution, agency, or person of his choice" (the "free choice of provider provision").[4] Whether or not a Medicaid beneficiary in South Carolina is able to meaningfully exercise the right to choose a provider is now a question before this Court, and the outcome of this case will have significant implications for reproductive justice.

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[3] *See, e.g.*, 111 Cong. Rec. 505 (1965) (statement of Rep. Pelly) ("[T]he doctors have been fearful—and rightly so—of steps that would eventually lead to government medicine. . . . I think the American people and most Members of Congress want free choice of hospital and doctor.").

[4] *See* S. Rep. No. 90-744, at 183 (1967), *as reprinted in* 1967 U.S.C.C.A.N. 2834, 3021 ("Under the current provisions of law, there is no requirement on the State that recipients of medical assistance under a State title XIX program shall have freedom in their choice of medical institution or medical practitioner. In order to provide this freedom, a new provision is included in the law to require States to offer this choice. . . . States are required to permit the individual to obtain his medical care from any institution, agency, or person, qualified to perform the service or services . . . .").

I. South Carolina's Actions Will Harm Women of Color and Their Communities

Medicaid is the largest source of public health insurance in the United States, covering sexual and reproductive health care and other vital health services for individuals with low incomes, including a disproportionate share of women of color, LGBTQ individuals, people with disabilities, and single parents.[5] Across the United States, forty million women rely on Medicaid for access to health care services,[6] including many women of color of reproductive age. Indeed, about 31% of Black women[7] and 27% of Hispanic women[8] of reproductive age are enrolled in the program, as are 27% of non-elderly American Indian and Alaska Native adults.[9] Nineteen percent of Asian American and Pacific Islander (AAPI) women are

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[5] NAPAWF et al., *Medicaid & Reproductive Justice Fact Sheet*, NAT'L LATINA INST. FOR REPROD. HEALTH 1 (Aug. 2018), http://latinainstitute.org/sites/default/files/Medicaid%2520and%2520RJ%2520Fact sheet.pdf.

[6] Hannah Katch et al., *Medicaid Works for Women—But Proposed Cuts Would Have Harsh, Disproportionate Impact*, CTR. ON BUDGET & POLICY PRIORITIES 1 (May 11, 2017), https://www.cbpp.org/sites/default/files/atoms/files/5-11-17health.pdf.

[7] Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, 20 GUTTMACHER POLICY REVIEW 39, 40 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2003917.pdf.

[8] *Id.*

[9] Samantha Artiga et al., *Medicaid and American Indians and Alaska Natives*, KAISER FAM. FOUND. (Sept. 2017), http://files.kff.org/attachment/issue-brief-medicaid-and-american-indians-and-alaska-natives.

enrolled in Medicaid, and these numbers are substantially higher for certain Asian ethnic subgroups.[10] Moreover, due to workplace discrimination and other systemic barriers, the LGBTQ community faces higher levels of poverty compared with the non-LGBTQ population. As a result, the Medicaid program is also critical to reducing health disparities, particularly for transgender people and LGBTQ women of color.[11]

As it does in other states, Medicaid insures a significant proportion of South Carolina's women of color.[12] Indeed, nearly 1 in 5 people in South Carolina have

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[10] For example, 62% of Bhutanese women, 43% of Hmong women, and 32% of Pakistani women are enrolled in the Medicaid program. NAPAWF et al., *supra* note 5, at 1.

[11] *Id.* at 3.

[12] In 2017, South Carolina Medicaid beneficiaries were about 60% female and 35% white. *Quick Facts About Medicaid Enrollment in South Carolina 2017*, http://www.schealthviz.sc.edu/Data/Sites/1/media/QuickFacts_SCMedicaidEnrollment.pdf. In 2016, over half of Medicaid beneficiaries nationwide were female (54%) and almost half were children (47%), compared with adults (42%) and senior citizens (11%). *National Context: Who Enrolls in Medicaid & CHIP?*, MEDICAID.GOV, https://www.medicaid.gov/state-overviews/scorecard/national-context/enrollment/index.html. In 2017, about one fifth of reproductive age women across the country were insured under Medicaid (13.2 million women aged 15-44); a disproportionate number of those beneficiaries were women of color (15.8% were white). *Gains in Insurance Coverage for Reproductive-Age Women at a Crossroads*, GUTTMACHER INST. (Dec. 4, 2018) [hereinafter GUTTMACHER, *Gains in Insurance Coverage*], https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads.

low incomes,[13] and 18% of all women of reproductive age in South Carolina are enrolled in Medicaid.[14] As with the Medicaid population nationwide, women of color make up a disproportionate share of women enrolled in Medicaid in South Carolina.[15] More than half of the state's Medicaid beneficiaries are women, and of those, 45% are African American, 6% are Hispanic, 1% are AAPI and 4% are of a race other than white, African American, Hispanic or AAPI.[16]

Because Medicaid covers health care services for individuals facing barriers to economic security, it is critical to advancing health equity for communities of color, and the success of the program depends upon a patient's ability to select and access trusted providers.

II. For Women of Color, Exercising the Right to Choose Their Own Health Care Provider is an Act of Agency Essential to Their Health

Since the founding moments of the United States, individuals living in poverty, women, and communities of color have been excluded from social, economic, and political power. Laws and policies have helped maintain these inequalities, and in many instances, have authorized reproductive oppression. Forced

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[13] *Key Data on Health and Health Coverage in South Carolina*, KAISER FAM. FOUND. (Feb. 10, 2016), https://www.kff.org/disparities-policy/fact-sheet/key-data-on-health-and-health-coverage-in-south-carolina/.
[14] GUTTMACHER, *Gains in Insurance Coverage*, *supra* note 12.
[15] Katch et al., *supra* note 6, at 15.
[16] *Id.*

sterilization,[17] blocked access to health care services and coverage,[18] and other reproductive injustices have constrained women of color's bodily autonomy and continue to shape their contemporary relationships to health care. The Medicaid program—strengthened by its free choice of provider provision and the private right of action that supports the provision's enforcement—represents a crucial step

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[17] Forced sterilization, whether of incarcerated women, poor women, or other women of color, has long been used as a tool of oppression and control. *See* ELENA R. GUTIÉRREZ, FERTILE MATTERS: THE POLITICS OF MEXICAN-ORIGIN WOMEN'S REPRODUCTION 35-54 (2008) (discussing the forced sterilization of Mexican-origin women in Los Angeles); Alexandra Minna Stern, *Sterilized in the Name of Public Health: Race, Immigration, and Reproductive Control in Modern California*, 95 AM. J. PUB. HEALTH 1128 (2005) (exploring the history of involuntary, federally-funded sterilization of women of color in California); Sally J. Torpy, *Native American Women and Coerced Sterilization: On the Trail of Tears in the 1970s*, 24 AM. INDIAN CULTURE & RES. J. 1 (2000) (documenting the abusive, federally-funded sterilization of thousands of Native American women in the 1970s); Kathryn Krase, *History of Forced Sterilization and Current U.S. Abuses*, OUR BODIES, OURSELVES (Oct. 1, 2014), https://www.ourbodiesourselves.org/book-excerpts/health-article/forced-sterilization/ (describing historical and continued forced sterilizations of women of color and incarcerated women).

[18] *See, e.g.*, 8 U.S.C. § 1613 (2015) (adding a five-year ban on accessing public benefit programs for "qualified" immigrants); *A Quick Guide to Immigrant Eligibility for ACA and Key Federal Means-Tested Programs*, NAT'L IMMIGRATION LAW CENTER (Apr. 2018) https://www.nilc.org/wp-content/uploads/2015/11/imm-eligibility-quickguide-2015-09-21.pdf (noting categorically that certain groups of immigrants are ineligible to access government programs); Jessica Arons & Madina Agénor, *Separate and Unequal: The Hyde Amendment and Women of Color*, CTR. FOR AM. PROGRESS (Dec. 2010), https://cdn.americanprogress.org/wp-content/uploads/issues/2010/12/pdf/hyde_amendment.pdf (discussing the Hyde Amendment's targeting of women of color and the consequential harm from banning abortion funding).

forward in mitigating racial, ethnic, and economic inequalities that contribute to inequities in health.

A. Access to high quality, respectful health care is already limited for women of color with Medicaid insurance

Even with Medicaid coverage, low-income women of color face significant barriers to appropriate health care, including a dearth of providers within reach who accept Medicaid, biases in health care delivery, mistrust between patients and health care providers, and language barriers that discourage individuals from accessing care.

First, due to low reimbursement rates, not all health care providers accept Medicaid.[19] Fewer physicians are willing to accept new Medicaid patients than patients with Medicare or private insurance, leaving Medicaid patients with limited provider options.[20] In South Carolina, only a little over 70% of physicians are willing to provide services to new patients with Medicaid.[21]

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[19] Xinxin Han et al., *Reports of Insurance-Based Discrimination in Health Care and Its Association With Access to Care*, 105 AM. J. OF PUB. HEALTH S517, S517 (2015).
[20] Esther Hing et al., *Acceptance of New Patients with Public and Private Insurance by Office-Based Physicians: United States, 2013*, NAT'L CTR. FOR HEALTH STAT. 1 (Mar. 2015), https://www.cdc.gov/nchs/data/databriefs/db195.pdf.
[21] *Id*. at 5.

Second, structural, institutional, and interpersonal racism impacts health care access and outcomes, influencing whether an individual receives the care they need and whether that care is high-quality. Evidence shows that discrimination and racial bias within and beyond the health care system contributes to poor health outcomes for Black patients and other racial and ethnic minorities.[22] "Higher levels of implicit bias among clinicians have been directly linked with biased treatment recommendations in the care of Black patients… [and] ha[ve] also been associated with poorer quality of patient-physician communication and lower patient ratings of the quality of the medical encounter."[23] Research from across the medical field shows that patients of color are treated with less empathy and urgency than white patients, and receive lower quality care, whether they need cardiac treatment, pain medication, a kidney transplant, or medical care during childbirth.[24] Given historical

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[22] David R. Williams & Ronald Wyatt, *Racial Bias in Healthcare and Health Challenges and Opportunities*, 314 J. AM. MED. ASS'N 555, 555-56 (2015).

[23] *Id.* at 555.

[24] *See Id.*; Elizabeth Howell et al., *Black-White Differences in Severe Maternal Morbidity and Site of Care*, 214 AM. J. OBSTETRICS & GYNECOLOGY 122, (2016) (demonstrating variations in quality of care between facilities that serve mostly Black patients and those that serve mostly white patients, with Black women suffering severe maternal morbidity at higher rates when birthing at hospitals that serve a high proportion of Black patients, even after adjusting for sociodemographic characteristics, clinical factors, and hospital characteristics); Janice A. Sabin & Anthony G. Greenwald, *The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma*, 102 AM. J. PUBLIC HEALTH 988, 991 (2012) (showing that pediatricians' implicit attitudes and

legacies of medical abuse and the lingering presence of bias in modern health care, women of color may be less likely to trust providers they have not been able to select freely. Thus, denying patients the option of choosing a provider whom they do trust can have negative consequences for their health.

Third, for some women of color, language barriers in health care settings can limit access to high quality care. For example, approximately 35% of Asian Americans and Pacific Islanders are limited English-proficient and have difficulty speaking, reading, writing, or understanding English.[25] Eleven percent of Latinos born in the United States are limited English-proficient and 66% of foreign-born Latinos are limited English-proficient.[26] Language barriers have been shown to deter people from accessing and benefitting from health care. For example, a study in

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stereotypes about race affect their decisions about children's pain management, with their likelihood of prescribing narcotic pain medication to Black patients decreasing as their pro-white bias increased); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. OF MED. 618, 621-625 (1999) (showing that race and sex independently influence physicians' decisions about how to manage patients complaining of chest pain, with Black women being significantly less likely to be referred for cardiac catheterization than white men).

[25] Karthick Ramakrishnan & Farah Z. Ahmad, *Language Diversity and English Proficiency*, CTR. FOR AM. PROGRESS 3 (May 27, 2014). https://www.americanprogress.org/wp-content/uploads/2014/04/AAPI-LanguageAccess1.pdf.

[26] Jens Manuel Krogstad et al., *English Proficiency on the Rise Among Latinos*, PEW RESEARCH CENTER (May 12, 2015), http://www.pewhispanic.org/2015/05/12/english-proficiency-on-the-rise-among-latinos/.

South Carolina found that language barriers "affected [immigrant] women's confidence to make medical appointments and understand all the information conveyed during a typical visit."[27]

Each of these factors—a dearth of nearby providers who accept Medicaid, racial and ethnic biases in health care that contribute to distrust, and language barriers—make it essential that women of color with Medicaid insurance have the freedom to choose a provider with whom they feel comfortable and who is capable of providing them with high-quality care that meets their individual needs. Giving states unfettered power to exclude qualified, committed providers from Medicaid for political reasons unrelated to health care would exacerbate the barriers that low-income women of color already face, regardless of what type of care they seek.

B. Access to culturally competent, trusted providers is critical for women of color seeking sexual and reproductive health care services

While the ability to choose a provider without improper state interference benefits all Medicaid beneficiaries, loss of this right would uniquely impact low-income women of color seeking sexual and reproductive health services, including many immigrant women, women with disabilities, and LGBTQ individuals. Access

[27] John S. Luque et al., *Access to Health Care for Uninsured Latina Immigrants in South Carolina*, BMC HEALTH SERVS. RES. 6 (2018), https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-018-3138-2

to sexual and reproductive health services for women of color must be viewed in the context of a long history of reproductive oppression, whereby both states and private parties have sought to control the bodily autonomy of people who they deemed unfit for reproduction, or undeserving of the freedom to make decisions for and about themselves and their families. The reproductive oppression of women of color manifests as both blocked access to health care services and forced medical procedures.

For example, key developments in the early field of gynecology were made by medical practitioners who performed brutal surgeries on enslaved Black women, without anesthesia.[28] Not only were enslaved women denied bodily autonomy while being tortured during medical experiments, they were also subjected to sexual violence, forced to bear children, and often deprived of the right to raise those children.

After slavery, women of color in the United States were targeted for compulsory sterilization. Tied to the eugenics movement, compulsory sterilization efforts sought to control the reproductive autonomy of individuals deemed "undesirable" by society—including people of color, those who were incarcerated, people with disabilities, and people with low incomes. In *Buck v. Bell*, 274 U.S. 200

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[28] DEIRDRE COOPER OWENS, MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGIN OF AMERICAN GYNECOLOGY 11 (2017).

(1927), the Supreme Court upheld Virginia's eugenic sterilization law, which permitted the forcible sterilization of thousands of men and women.

The legacy of sterilization abuse has profoundly affected Black communities across the South. Between 1964 and the mid-1970s, approximately 65% of the women sterilized in North Carolina were African American.[29] In a practice so common it came to be known as the "Mississippi appendectomy," medical students in the South developed their surgical skills by performing unnecessary hysterectomies on poor Black women at teaching hospitals, without their informed consent.[30] In *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977), a legal challenge was brought by Mary Alice and Minnie Relf of Alabama, poor African-American sisters with intellectual disabilities who were sterilized at the ages of 14 and 12. Their mother, who was illiterate, had been misled to believe she had given permission for her daughters to receive birth control shots. The lawsuit revealed that 100,000 to 150,000 poor people were being sterilized each year under federally-funded programs. *Id.* at 1199.

Sterilization abuses have been perpetrated against other communities of color as well. During the late 1960s and early 1970s, low-income, immigrant, Mexican

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[29] *See* ANGELA Y. DAVIS, WOMEN, RACE, & CLASS 217(1st ed. 1983).
[30] DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 90 (2d ed. 2017).

women in Los Angeles were coercively sterilized by medical practitioners who believed that "poor minority women in L. A. County were having too many babies."[31] In the 1960s and 70s, the Indian Health Service sterilized approximately one quarter of all Native American women.[32] And between 2006 and 2013, nearly 30% of tubal ligations performed on women incarcerated in the California prison system were done without legal consent, many on women of color.[33] Thus, for many women of color seeking sexual and reproductive health services, the history of sterilization abuse informs the type of provider and care they seek.

Women of color have also suffered exploitation as new reproductive health technologies are developed. The first oral contraceptive, Enovid, was tested on Puerto Rican and Haitian women in the 1950s before the U.S. Food and Drug Administration (FDA) approved it for distribution in 1960.[34] Thereafter, Mexican

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[31] *See* Stern, *supra* note 17, at 1135.
[32] *Sterilization Abuse: A Proposed Regulatory Scheme*, 28 DEPAUL L. REV. 731, 733 n.14 (1979).
[33] CALIFORNIA STATE AUDITOR, REPORT 2013-120, STERILIZATION OF FEMALE INMATES: SOME INMATES WERE STERILIZED UNLAWFULLY AND SAFEGUARDS DESIGNED TO LIMIT OCCURRENCES OF THE PROCEDURE FAILED 1, 1940 (2014), https://www.auditor.ca.gov/pdfs/reports/2013-120.pdf (noting that 30 of the 144 inmates who received sterilization procedures from 2005 to 2012 did not provide fully informed consent).
[34] Theresa Vargas, *Guinea Pigs or Pioneers? How Puerto Rican Women Were Used To Test the Birth Control Pill.*, WASH. POST (May 9, 2017), https://www.washingtonpost.com/news/retropolis/wp/2017/05/09/guinea-pigs-or-pioneers-how-puerto-rican-women-were-used-to-test-the-birth-control-pill/?utm_term=.505f9b4fa2e8.

American women participated in medical testing for contraception without informed consent, resulting in half of participants unknowingly ingesting placebo medication.[35]

Family planning decisions are deeply personal, and patients often consider their past, present, and future as they make decisions about contraception. While all women deserve access to effective and affordable contraception, women who have been excluded from the benefits of reproductive health advances and/or exploited during their development may be especially concerned about coercion with regard to their reproductive decision-making. In this context, a woman of color's ability to freely choose the form of contraception that is best for her may very well depend upon her ability to select a provider whom she trusts to provide comprehensive information, options, and services in an atmosphere of respect and non-judgment.

III. Access to Qualified Reproductive Health Providers Like Planned Parenthood is Crucial for Women of Color in South Carolina

In 2014, the last year for which data is available, 323,140 of South Carolina's women and girls aged 13-44 were in need of publicly funded contraceptive

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[35] Lisa Cacari-Stone & Magdalena Avila, *Rethinking Research Ethics for Latinos: The Policy Paradox of Health Reform and the Role of Social Justice*, 22 J. ETHICS & BEHAV. 445, 449 (2012), https://www.tandfonline.com/doi/abs/10.1080/10508422.2012.729995.

services.[36] Almost 50% of those women were white, 39% were Black, and about 7% were Hispanic.[37] For many of these women, Medicaid coverage that encompasses family planning services at providers like Planned Parenthood is a critical resource.

A. Denying Medicaid patients access to Planned Parenthood goes against the public interest, putting the health of women of color in South Carolina at risk, and potentially exacerbating disparities

South Carolina's efforts to cut off its residents' access to Planned Parenthood will undermine public health in the state and will disproportionately harm women of color with low incomes. Women of color already face numerous reproductive health disparities and cannot afford to lose access to trusted providers. For example, Black women have higher breast cancer mortality rates compared to other racial and ethnic groups[38] and Latina women have the highest incidence rates of cervical cancer.[39] Cervical cancer rates are also higher in some Native Hawaiian and Pacific Islander

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[36] Jennifer J. Frost et al., *Contraceptive Needs and Services, 2014 Update*, GUTTMACHER INST. 22 (Sept. 2016), https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[37] *Id.*

[38] Lisa C. Richardson et al., *Patterns and Trends in Age-Specific Black-White Differences in Breast Cancer Incidence and Mortality – United States, 1999-2014*, CTS. FOR DISEASE CONTROL & PREVENTION (Oct. 14, 2016), https://www.cdc.gov/mmwr/volumes/65/wr/mm6540a1.htm#suggestedcitation.

[39] *Cervical Cancer & Latinxs: The Fight for Prevention & Health Equity*, NAT'L LATINA INST. FOR REPROD. HEALTH 1 (Jan. 2018), http://www.latinainstitute.org/sites/default/files/NLIRH_CervicalCancer_FactSheet18_Eng_R1.pdf.

and American Indian and Alaska Native subgroups than they are among non-Hispanic whites.[40] Similarly, because of socioeconomic, cultural, and gender barriers, and a lack of access to comprehensive sex education, women of color are disproportionately impacted by STDs, including HIV. Between 2012 and 2016, diagnoses of HIV increased for American Indians, Alaska Natives, and Asians,[41] and in 2016, Hispanics/Latinos accounted for 26% of the new HIV diagnoses in the United States.[42] Of the total number of women living with diagnosed HIV at the end of 2015, 59% were African American.[43]

In South Carolina specifically, women face myriad health challenges and a dearth of supportive policies that might alleviate them. In 2018, South Carolina ranked 40th in the country on maternal mortality, with Black women dying at rates

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[40] *See Cancer and Native Hawaiians/Pacific Islanders*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF MINORITY HEALTH, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=76 (Oct. 2, 2018); *Cancer and American Indians/Alaska Natives*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF MINORITY HEALTH, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=31 (Nov. 6, 2016).

[41] *HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas*, CETS. FOR DISEASE CONTROL & PREVENTION 6 (2017), https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2017-vol-29.pdf.

[42] *HIV and Hispanics/Latinos*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html (Nov. 1, 2018).

[43] *HIV Among Women*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/hiv/group/gender/women/index.html (July 5, 2018).

four times higher than white women in the State, and far above the national average.[44] South Carolina also ranked poorly on preterm birth (46th),[45] low birthweight (45th),[46] and prevalence of chlamydia among women (45th).[47] Benchmarked against national averages that are already considered poor compared to other developed countries, a separate analysis ranked South Carolina 37th overall on women's and children's health and well-being.[48] The rates of infant mortality, child mortality, and teen mortality in South Carolina are all above the national average,[49] and communities of color and people with low incomes routinely bear a disproportionate burden of these poor health outcomes.

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[44] America's Health Rankings, *Maternal Mortality in South Carolina in 2018*, UNITED HEALTH FOUND., https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/SC.
[45] America's Health Rankings, *Preterm Birth in South Carolina in 2018*, UNITED HEALTH FOUND., https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/pretermbirth_MCH/state/SC.
[46] America's Health Rankings, *Low Birthweight in South Carolina in 2018*, UNITED HEALTH FOUND., https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/lowbirthweight_MCH/state/SC.
[47] America's Health Rankings, *Chlamydia – Women in South Carolina in 2018*, UNITED HEALTH FOUND., https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/chlamydia_women/state/SC.
[48] Bridgit Burns et al., *Evaluating Priorities: Measuring Women's and Children's Health and Wellbeing Against Abortion Restrictions in the States, State Brief: South Carolina*, IBIS REPROD. HEALTH 5 (Dec. 2014), https://ibisreproductivehealth.org/sites/default/files/files/publications/Ibis%20Reproductive%20Health_Priorities_SC_FINAL_120514.pdf.
[49] *Id.* at 6.

South Carolina lawmakers have spent substantial time and energy restricting reproductive health care in the state. South Carolina has some of the most numerous and burdensome abortion restrictions in the country and the state legislature consistently introduces additional measures to ban and impede reproductive health care.[50] Notably, South Carolina has been slower to implement evidence-based policies known to support women's and children's health and well-being.[51] For instance, the state has rejected expansion of Medicaid under the Affordable Care Act, has set conservative Medicaid income limits for pregnant women, and does not require insurers that cover prescription drugs to provide coverage for FDA-approved contraceptives.[52]

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[50] South Carolina currently has fifteen abortion restrictions on the books. In the 2017 and 2018 legislative sessions five additional restrictions including a 6-week abortion ban, a ban on the standard of care after approximately 15 weeks, and an attempt to define fertilization as personhood were introduced.

[51] Terri-Ann Thompson & Jane Seymour, *Evaluating Priorities: Measuring Women's and Children's Health and Wellbeing Against Abortion Restrictions in the States*, IBIS REPROD. HEALTH 12-13 (June 2017) (providing a list of evidence-based supportive policies and highlighting that South Carolina has implemented few of them). https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf.

[52] *Id*. at 38- 40 ("Low-income women without health insurance are more likely to report going without needed care, are less likely to have a regular health care provider, and are less likely to access preventive services than low-income women with health insurance"; similarly, "[i]ncreased Medicaid eligibility limits for pregnant women has been shown to increase health coverage of pregnant women and to reduce infant mortality and low birth weight"; and contraceptive parity laws

Maintaining access to qualified health care providers like Planned Parenthood is critical to addressing these disparities and the gaps in South Carolina's safety net.[53] Family planning providers help to reduce unintended pregnancies, preterm and low birthweight births, sexually transmitted infections, and cases of cervical cancer.[54] Reducing access to health care and preventing women from choosing providers that they trust is counterproductive and goes against the public interest in advancing public health in South Carolina.

B. Planned Parenthood is a highly qualified provider of reproductive health care services upon which women of color depend

Planned Parenthood plays a uniquely crucial role in safeguarding the health of women of color in South Carolina, many of whom rely on Planned Parenthood for essential family planning services that enable them to plan their pregnancies,

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"insure that women are able to access effective, more affordable contraceptives through their insurance and avoid unintended pregnancy.").

[53] Anti-poverty programs and other government resources that assist people facing economic hardship are often referred to collectively as a "safety net." Such programs may include nutrition assistance, health care, childcare, and more.

[54] For example, Title X (a federal program that covers family planning services) improves people's health beyond helping them plan and space their pregnancies: "In 2010 (the most recent year for which these data are available), the services provided within the Title X network prevented 87,000 preterm or low-birth-weight births, 63,000 STIs and 2,000 cases of cervical cancer." Kinsey Hasstedt, *Why We Cannot Afford to Undercut the Title X National Family Planning Program*, 20 GUTTMACHER POL'Y REV. 20, 21 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2002017.pdf.

maintain their health, and self-determine a future for themselves and their families. Nationally, Planned Parenthood provides around 9.5 million clinical services to approximately 2.4 million patients a year,[55] more than one third of whom are women of color.[56] Planned Parenthood South Atlantic, the affiliate that serves South Carolina, provides a full range of reproductive health and women's health care services at their Charleston and Columbia locations. In addition to contraceptive care and STD screening and treatment, the Charleston and Columbia health centers provide breast exams, cervical cancer screenings, fibroid evaluation, and prenatal care referrals.[57] The Columbia health center also provides general health care including physicals, diabetes screening, flu vaccinations, and a range of additional services.[58]

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[55] PLANNED PARENTHOOD, 100 YEARS: 2016-2017 ANNUAL REPORT 7 (2017), https://www.plannedparenthood.org/uploads/filer_public/d4/50/d450c016-a6a9-4455-bf7f-711067db5ff7/20171229_ar16-17_p01_lowres.pdf.

[56] *The Irreplaceable Role of Planned Parenthood Health Centers*, PLANNED PARENTHOOD 1 (May 26, 2017), https://www.plannedparenthood.org/uploads/filer_public/2d/49/2d495908-6de0-4466-98a6-f25c456572b9/fact_sheet_-_irreplaceable_role_of_pp_health_centers_1.pdf.

[57] *Women's Health Care in Charleston, SC*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/health-center/south-carolina/charleston/29407/charleston-health-center-4288-90860/womens-health.

[58] *General Health Care in Columbia, SC*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/health-center/south-carolina/columbia/29204/columbia-health-center-2646-90860/general-health.

A provider's expertise in sexual and reproductive health and ability to provide a safe, accepting environment is highly valued by patients seeking family planning services. As a result, many women seeking contraception choose specialized family planning providers like Planned Parenthood. The primary reasons patients cite for deciding to seek care at such facilities include being treated respectfully by staff, confidential services, free or low-cost services, and staff knowledge about women's health care services.[59] For many LGBTQ individuals of color seeking affirming sexual and reproductive health care, Planned Parenthood offers a comprehensive range of services specifically addressing LGBTQ medical needs, including gender-affirming care.[60] The expansive set of services offered by Planned Parenthood can be especially important to women of color who use Planned Parenthood as their primary source of health care. In these instances, Planned Parenthood serves as an important entry point into the health care system for women of color and their families.[61]

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[59] Jennifer J. Frost et al., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 WOMEN'S HEALTH ISSUES e519, e523 (2012), https://www.whijournal.com/article/S1049-3867(12)00073-4/pdf.

[60] *See LGBT Services in Charleston, SC,* PLANNED PARENTHOOD, https://www.plannedparenthood.org/health-center/south-carolina/charleston/29407/charleston-health-center-4288-90860/lgbt.

[61] A study of women's reasons for seeking care at specialized family planning clinics found that for four out of ten respondents it was their only source of health care. Frost, *supra* note 59, at e524.

IV. Access to Justice and Remedies for Rights Violations Are Essential to People Who Depend on Medicaid for Their Health Care and They Must be Preserved

In addition to arguing that states have unfettered power to terminate providers' Medicaid contracts for reasons unrelated to the quality of care they offer, South Carolina contends that none of the provisions of the federal Medicaid Act, including the 83 provisions under § 1396a(a), confer private rights that patients may sue to enforce under 42 U.S.C. § 1983. If the State's arguments are accepted, the harm to Medicaid beneficiaries could be far-reaching.

For decades, Medicaid beneficiaries have enforced their rights under the Medicaid statute through § 1983 actions in the courts. Indeed, this Court has held that a specific provision under § 1396a(a), § 1396a(a)(8), created a private right enforceable under § 1983. *See Doe v. Kidd*, 501 F.3d 348, 356-357 (4th Cir. 2007) (holding that provisions of Medicaid Act could confer an enforceable private right as long as specific statute contains rights-creating language in accordance with *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), and *Blessing v. Freestone*, 520 U.S. 329 (1997)). Many other courts have held similarly. *See, e.g., Bontrager v. Indiana Family & Soc. Servs. Admin.*, 697 F.3d 604, 606-08 (7th Cir. 2012) (finding a private right of action under 42 U.S.C. § 1396a(a)(10)(A) to challenge a limit on dental services); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602-07 (5th Cir. 2004) (same under § 1396a(a)(10)(A)(i) and § 1396d(a)(4)(B) for children's "early and periodic

screening, diagnostic, and treatment services" and care); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir. 2004) (same under § 1396a(a)(10), § 1396a(a)(8), and § 1396d(a)(15), requiring States to provide, with reasonable promptness, medical assistance for intermediate care facilities). These cases have provided meaningful relief for Medicaid beneficiaries when states have failed to comply with their duties and obligations under the Medicaid Act.

What is at stake for Medicaid beneficiaries cannot be overstated. By definition, people with Medicaid insurance rely on their Medicaid benefits in order to obtain medical care, and without these benefits, they are unable to afford the medical care they need. *See Goldberg v. Kelly*, 397 U.S. 254, 264 (1970) ("For qualified recipients, welfare provides the means to obtain essential food, clothing, housing, and medical care."). When state Medicaid programs take actions that violate these rights, Medicaid beneficiaries' access to medically necessary health care is jeopardized. Individually enforceable rights are vital to ensuring that Medicaid beneficiaries can access such care from qualified providers that they trust.

Moreover, enforcement mechanisms provide a critical avenue for communities of color and populations that have been systematically disenfranchised and marginalized by our political and legal systems to seek justice in the courts, in line with the broader purpose and history of § 1983, which was intended to enforce the Fourteenth Amendment to the U.S. Constitution and provide a federal remedy to

African Americans subjected to state deprivations of their rights. In the face of state actions and laws that have intentionally targeted and discriminated against them, communities of color have long relied on the courts to seek justice when no other recourse was available, and courts have played a necessary role in protecting basic civil and human rights.

In the context of enforcement of the Medicaid Act, § 1983 actions have ensured that women of color are able to bring their grievances to court and have their voices heard. Thus, the private right of action has "served the very purpose of 1983" which "was to interpose the federal courts between the States and the people, as guardians of the people's federal rights." *Mitchum v. Foster*, 407 U.S. 225, 242 (1972). *See also id*. at 239 ("Section 1983 opened the federal courts to private citizens, offering a uniquely federal remedy against incursions under the claimed authority of state law upon rights secured by the Constitution and laws of the Nation.").

A private right of action has been—and continues to be—integral to women of color gaining full agency in their lives, families, and communities, providing them with the power to vindicate their own rights related to the health and medical care they need. Stripping away an individual's right to sue would injure the legal agency and dignity of women of color, in addition to the injuries to agency and dignity in health care that the State's actions in this case inflict.

CONCLUSION

Medicaid insurance serves as a critical access point for women of color with low incomes seeking a variety of essential health care services. Affirming a Medicaid beneficiary's right to choose a qualified provider whom they trust improves access to health care and serves the public interest. Women of color in South Carolina already face significant barriers to health care, which will only be exacerbated by depriving Medicaid beneficiaries of their right to choose a willing and qualified provider. Moreover, a private right of action has been critical for Medicaid beneficiaries in ensuring that states comply with their duties under the Medicaid Act, including their obligation to afford Medicaid beneficiaries the opportunity to choose a qualified provider. For the reasons set forth above and in the brief of the Plaintiffs-Appellees, this Court should uphold the District Court's decision.

Respectfully submitted,

/s/ Julie Rikelman

JULIE RIKELMAN
Counsel of Record
PILAR HERRERO
AMY MYRICK
CAROLINA VAN DER MENSBRUGGHE
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street, 22nd Floor
New York, NY 10038
(917) 637-3600
jrikelman@reprorights.org

JANE LIU
MARIAH LINDSAY
NATIONAL ASIAN PACIFIC AMERICAN
WOMEN'S FORUM
1730 Rhode Island Avenue, NW, Suite 210
Washington, DC 20036
(773) 251-8440
jliu@napawf.org

Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE WITH RULE 32(A)

1. This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,234 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Office Word in 14-point, Times New Roman font.

Date: January 22, 2019

/s/ Julie Rikelman
JULIE RIKELMAN

CERTIFICATE OF SERVICE

I certify that on January 22, 2019 the foregoing document was served via electronic filing on all parties or their counsel of record in this case.

Date: January 22, 2019

/s/ Julie Rikelman
JULIE RIKELMAN

ADDENDUM: LIST OF *AMICI*

Access Reproductive Care—Southeast provides funding and logistical support to ensure Southerners receive safe and compassionate reproductive care including abortion services. Through education and leadership development we build power in communities of color to abolish stigma and restore dignity and justice.

The Center for Reproductive Rights is a global human rights organization that uses the law to advance reproductive freedom as a fundamental right that all governments are legally obligated to respect, protect, and fulfill. In the United States, the Center focuses on ensuring that all people have access to a full range of high-quality reproductive health care. Since its founding in 1992, the Center has been involved in nearly all major litigation in the U.S. concerning reproductive rights, including as lead counsel for the plaintiffs in Whole Woman's Health v. Hellerstedt. The Center has a vital interest in ensuring that all individuals have equal access to reproductive health care services.

In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national Reproductive Justice organization focused on lifting up the voices of Black women at the national and regional levels in our ongoing policy fight to secure Reproductive Justice for all women and girls. Formed in 2014, In Our Own Voice is a national-state partnership with eight Black women's organizations: Black Women for Wellness, Black Women's Health Imperative, New Voices for Reproductive Justice, SisterLove, Inc., SisterReach, SPARK Reproductive Justice NOW, The Afiya Center and Women With A Vision. As a Reproductive Justice organization, we believe that women have the human right to control our bodies, our sexuality, our gender, our work, and our reproduction. That right can only be achieved when all women and girls have the complete economic, social, and political power and resources to make healthy decisions about our bodies, our families, and our communities in all areas of our lives. The goals of In Our Own Voice are: (1.) To establish a leadership voice for Black women on reproductive rights, health and justice policy at the national level; (2.) To build a coordinated grassroots movement of Black women in support of abortion rights and access, including ending the onerous funding restrictions, contraceptive equity and comprehensive sex education; (3.) To lay the foundation for ongoing policy change at the national and state levels that impacts the lives and wellbeing of Black women and their families; and (4.) To engage and motivate Black women as a

traditionally underrepresented group to use their voting power in the American electorate.

The National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue Asian American and Pacific Islander (AAPI) women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for AAPI women, girls, and transgender and gender non-conforming people. NAPAWF approaches all of its work through a reproductive justice framework that seeks for all members of the AAPI community to have the economic, social, and political power to make their own decisions regarding their bodies, families, and communities. Our work includes advocating for the reproductive health care needs of AAPI women and ensuring AAPI women's access to reproductive health care services, including abortion care services.

National Latina Institute for Reproductive Health (NLIRH) is the only national reproductive justice organization dedicated to advancing health, dignity, and justice for the 28 million Latinas, their families, and communities in the United States. Through leadership development, community mobilization, policy advocacy, and strategic communications, NLIRH works to further affordable access to comprehensive healthcare for all Latinxs, of all ages and immigration statuses. NLIRH believes that the human right to healthcare is essential to ensuring that all people can shape their lives and futures with dignity.

The Women's Rights and Empowerment Network (WREN) is a nonpartisan, nonprofit organization whose mission is to build a movement to advance the health, economic wellbeing and rights of South Carolina's women, girls, and their families.