ALLABOVEALL

WHAT'S AT STAKE IN THE SUPREME COURT'S MIFEPRISTONE CASE?

OVERVIEW

This summer, the U.S. Supreme Court is expected to rule in FDA v Alliance for Hippocratic Medicine, which concerns access to one of two pills typically used together to provide medication abortion care. The outcome of this case threatens to place abortion care further out of reach for everyone in the United States, especially those working to make ends meet, rural folks, immigrants, and Black, Indigenous, and people of color.

KEY POINTS

- Most abortions in the United States today are medication abortions.
- Despite decades of evidence showing medication abortion to be safe and effective, many states restrict access, and restrictions could be exacerbated by the Supreme Court's ruling.
- While everyone should be able to choose the abortion method that is right for them, access to medication abortion is especially important for people who can't get to a clinic because they are in a rural area, lack transportation, or live in a state where abortion has been banned, and for those who need to obtain abortion care privately to avoid stigma or violence.
- The outcome of this case would impact all 50 states, not just states with abortion bans, and could stretch the capacity of existing abortion providers to the breaking point.
- Lifting barriers to medication abortion is essential to abortion justice and ensuring that each of us can get abortion care, whoever we are and wherever we live.

BACKGROUND

A single, 200 mg mifepristone pill, approved by the FDA in 2000, is the first half of the two-step regimen typically used to provide medication abortion care in the United States. In 2023, medication abortion accounted for about two-thirds of U.S. abortions.[1]

Despite voluminous evidence that mifepristone is both safe and effective,[2] more than half of U.S. states have erected barriers to medication abortion access. Fourteen states have banned all or most abortions entirely, and another 15 states specifically restrict access to medication abortion.[3] Potential restrictions on medication abortion escalated to the national level in April 2023, when a federal court in Texas ruled to overturn the FDA's approval of mifepristone.

An appeals court later ruled that because more than two decades had passed since FDA approval, mifepristone could not be entirely removed from the U.S. market. However, the appeals court determined that later FDA modifications of the approval, which broadened access to mifepristone by loosening restrictions on how it can be administered, should be reversed. Enforcement of these rulings has been suspended by the U.S. Supreme Court, which will hear oral arguments in the case on March 26 and is expected to issue a decision this summer.

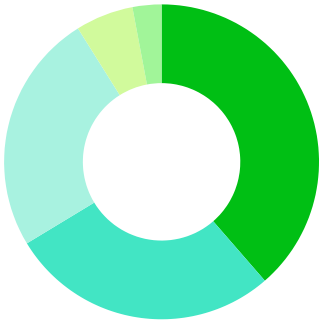
WHAT'S AT STAKE

Communities contending with systemic racism and economic injustice, who often lack access to quality health care and undertake exhausting efforts to support their families, are most likely to need abortion care and therefore suffer the greatest harm when abortion is restricted.

One of the effects of systemic racism in this country is that people of color and those working to make ends meet are disproportionately likely to have an abortion.

Abortion patients by race

- **39%** White
- **28%** Black
- **25%** Hispanic/Latinx
- **6%** Asian/Pacific Islander
- **3%** Other



Abortion patients below the poverty level by income

- **49%** Below poverty level
- **26%** Up to 2x poverty level
- **25%** >2x poverty level

1 Rachel K. Jones and Amy Friedrich-Karnik. Medication Abortion Accounted for 63% of All US Abortions in 2023—An Increase from 53% in 2020. Guttmacher Institute policy analysis, March 18, 2024.
2 EMAA Project. The Safety and Efficacy of Medication Abortion Care, February 24, 2022.
3 Amy Friedrich-Karnik, Emma Stoskopf-Ehrlich, and Rachel K. Jones. Medication Abortion Within and Outside the Formal US Healthcare System: What You Need to Know. Guttmacher Institute Policy Analysis, February 2024.

As a result of systemic racism, people of color and low income people make up the majority of U.S. abortion patients.[4]

The Supreme Court ruling on mifepristone could specifically jeopardize people working to make ends meet, rural folks, immigrants, and Black, Indigenous, and people of color in several ways.

For one, the Court could roll back the time frame for mifepristone use from the current standard of 10 weeks back to just 7 weeks – before many people even know they are pregnant. Such a ruling would force many people who might prefer medication abortion to instead seek surgical abortion from a brick-and-mortar provider. For some people, this can mean traveling 200 miles or more.[5] Clinics are hardest to reach for people living in rural areas and those living in states and regions where abortions are banned – primarily states in the South and Midwest, the parts of the country that are also home to the largest proportions of Black people.

Abortion bans fall hardest on people already coping with systemic injustice.

4 Jenna Jerman, Rachel K. Jones and Tsuyoshi Onda. Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008. Guttmacher Institute Report, May 2016.
5 Caitlin Myers. Myers Abortion Facility Database; Caitlin Myers. Forecasts for a post-Roe America: The effects of increased travel distance on abortions and births. Journal of Policy Analysis and Management 43(1): 39-62.

People seeking abortions in states that have or are likely to impose strict restrictions are more likely to be Black and to have difficulty paying for their abortions.[6]

The Court could also require that patients obtain mifepristone directly from a physician rather than from a pharmacy, and could require that medication abortion patients make three in-person visits to a physician. Instead of having abortions privately at home, via telemedicine visits and medications obtained at a local pharmacy or through the mail, patients would have to travel to clinics, possibly multiple times.

Being forced to travel is especially burdensome for working class people, those without paid sick leave, parents who need to arrange child care, and people who lack transportation or drivers' licenses. For people needing to raise money to travel, an in-person requirement could push abortion later in pregnancy or place it out of reach.

An in-person requirement also makes abortion less private. Some people seek abortions because they are facing challenging or abusive personal situations. Being forced to visit an abortion clinic – or being denied access to abortion altogether – can subject already vulnerable people to stigma and potential violence.

If the Supreme Court's decision makes medication abortion illegal or inaccessible in some states, people living in these places would be left with limited options. They could seek a surgical abortion, possibly in another state – but restrictions on medication abortion would likely drive a dramatic increase in demand for surgical abortions. With clinics overwhelmed, patients would be forced to travel further and wait longer. For some, these obstacles would likely be insurmountable.

They could self-induce abortion. While the evidence suggests that self-managed medication abortion is generally safe, it brings a significant risk of criminalization. At least 61 people, disproportionately people of color, were criminalized for allegedly ending a pregnancy between 2000 – 2020. Medically unnecessary restrictions on medication abortion simply provide more opportunities for authorities to prosecute people – and the risks are greatest for people of color and others who are already more likely to be criminalized.

Or they could carry their pregnancies to term and give birth, a choice that can be especially dangerous for Black women and for those with unintended pregnancies. Maternal deaths in 2020 were 62% higher in states where abortion is heavily restricted than in states where abortion was available.[7] Whether Black women choose to end their pregnancy or carry it to term, they deserve the right to healthcare with dignity.

6 Rachel K. Jones and Doris W. Chu. Characteristics of abortion patients in protected and restricted states accessing clinic-based care 12 months prior to the elimination of the federal constitutional right to abortion in the United States. Perspectives on Sexual and Reproductive Health 55(2): 80-85.

7 Commonwealth Fund. The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions. Issue Brief, December 14, 2022.

WHAT YOU CAN DO

- Policymakers and advocates in states where abortion remains broadly legal can act to enshrine the right to abortion in their state constitution. They can be national leaders by enacting bold proactive policies to protect and expand abortion access (e.g., remove abortion coverage bans, enact shield laws to protect abortion patients and providers from out-of-state prosecutors, and remove laws that could criminalize self-managed abortions).

- Policymakers and advocates in states where abortion is banned or tightly restricted can continue to educate their peers and communities about the unjust and inhumane consequences of these restrictions.

- Everyone can help to push forward bold legislation such as the Abortion Justice Act and shape the future of abortion access: a world in which care is there for everyone who needs it, without barriers based on who you are, where you live, or how much you earn.

ABORTION JUSTICE BELONGS HERE

info@allaboveall.org
347.719.3255
allaboveall.org