UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA
CIVIL ACTION NO. 1:23-CV-00077

AMY BRYANT, M.D., Plaintiff, v. JOSHUA H. STEIN in his official capacity as Attorney General for the State of North Carolina, *et. al.*, Defendants, and PHILIP E. BERGER, in his official capacity as President Pro Tempore of the North Carolina Senate, and TIMOTHY K. MOORE, in his official capacity as Speaker of the North Carolina House of Representatives, Defendant-Intervenors.	**DEFENDANT SEC. KINSLEY'S RESPONSE TO INTERVENOR-DEFENDANTS' MOTION TO DISMISS**

Defendant Kody H. Kinsley, in his official capacity as Secretary of the North Carolina Department of Health and Human Services ("NCDHHS"), responds to Intervenor-Defendants' Rule 12(b)(6) Motion to Dismiss [D.E. 53], as follows.

NCDHHS is the State executive agency that manages the delivery of health- and human-related services for all North Carolinians, especially our most vulnerable citizens – children, elderly, disabled and low-income families. The Department works closely with health care professionals, community leaders and advocacy groups; local, state and federal entities; and many other stakeholders to make this happen.

Part of the NCDHHS mission is ensuring that health care is accessible for all North Carolinians, and that includes reproductive health services. Access to reproductive health services has a profound impact on women's lives and is an essential part of comprehensive health care. It is also an equity issue. Research shows that restrictions on reproductive health care rights have harmful consequences on individuals' health, safety, and economic stability.

For example, the Turnaway Study from the University of California, San Francisco (Foster *et al.*) showed restrictions on reproductive health care for women:

- Increase the risk of poverty, not being able to cover basic living expenses, having a lower credit score, increased debt, bankruptcies and evictions;

- Increase the risk of raising a child alone;
- Increase the risk of physical violence, and increase the likelihood of staying in contact with a violent partner;
- Increase the risk of more serious health problems, *e.g.*, eclampsia, postpartum hemorrhage, gestational hypertension, chronic headaches/migraines, joint pain;
- Increase the risk of children having to live in poverty, and enduring poorer maternal bonding.

See Advancing New Standards in Reproductive Health, The Turnaway Study, UNIV. OF CAL. S.F., www.ansirh.org/research/turnaway-study (last visited Apr. 27, 2023).

Research shows that restrictions to reproductive health care can increase infant mortality[1] and are associated with

[1] Karletsos, *Association of State Gestational Age Limit Abortion Laws with Infant Mortality*, American Journal of Preventive Medicine, (Aug. 4, 2021), https://doi.org/10.1016/j.amepre.2021.05.022 (last visited Apr. 27, 2023). *See also* Krieger, *Reproductive Justice and the Pace of Change: Socioeconomic Trends in US Infant Death Rates by Legal Status of Abortion, 1960–1980*, American Journal of Public Health, (*Apr. 1, 2015)*, https://doi.org/10.2105/AJPH.2014.302401 (last visited Apr.

higher risks of low birth weight, especially for children born to black women.[2] Research also shows restrictions on reproductive health care can increase maternal mortality.[3]

Reproductive health restrictions disproportionately impact people of color, people with disabilities, people with low incomes, and people who live in rural areas. *Id*.

27, 2023); Pabayo, *Laws Restricting Access to Abortion Services and Infant Mortality Risk in the United States*, Int. Journal of Environmental Research and Public Health, (May 26, 2020), https://www.mdpi.com/1660-4601/17/11/3773 (last visited Apr. 27, 2023).

[2] Wallace *et al*., *The Status of Women's Reproductive Rights and Adverse Birth Outcomes*, *Women's Health Issues,* (*Jan. 25,* 2017), https://doi.org/10.1016/j.whi.2016.12.013 (last visited Apr. 27, 2023). *See also* Sudhinaraset, *Women's Reproductive Rights Policies and Adverse Birth Outcomes: A State-Level Analysis to Assess the Role of Race and Nativity Status*, American Journal of Preventive Medicine, (Oct. 13, 2020), https://doi.org/10.1016/j.amepre.2020.07.025 (last visited Apr. 27, 2023).

[3] Ronsmans, *Maternal Mortality: Who, When, Where, and Why*, The Lancet, (Sept. 28, 2006), https://doi.org/10.1016/S0140-6736(06)69380-X (last visited Apr. 27, 2023); Latt, *Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries*, BMC Women's Health, (Jan. 5, 2019), https://doi.org/10.1186/s12905-018-0705-y (last accessed Apr. 27, 2023); Vilda, *State Abortion Policies and Maternal Death in the United States, 2015–2018*, American Journal of Public Health, (Sept. 22, 2021), https://doi.org/10.2105/AJPH.2021.306396 (last visited Apr. 27, 2021).

Black and Hispanic women get abortions at higher rates than their peers. In North Carolina, black people make up 23% of the population, but black women account for 49% of abortions. Latinos make up 10% of the population, but Latina women account for 13% of abortions.[4] Black women are more likely to have low birth weight babies in states with more restriction to reproductive rights.[5] Women of color experience higher poverty rates and are less likely to have health insurance providing access to contraception, leading to a greater occurrence of unintended pregnancies.[6] The North Carolina Maternal Mortality Review Committee revealed that black women were 1.8x more likely to die from

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[4] *Reported Legal Abortions by Race of Women Who Obtained Abortion by the State of Occurrence*, Kaiser Family Foundation, https://www.kff.org/womens-health-policy/state-indicator/abortions-by-race/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Apr. 27, 2023).

[5] *See* Sudhinaraset, n.2, *supra.*

[6] *See* Kerby, *The State of Women of Color in the United States,* The Center for American Progress, (July 17, 2012), https://www.americanprogress.org/article/the-state-of-women-of-color-in-the-united-states/ (last accessed Apr. 27, 2023).

pregnancy-related causes than white women in North Carolina.[7]

Access to reproductive health services is a public health issue. Reducing reproductive access runs counter to substantial evidence from public health and preventive medicine researchers regarding the considerable health benefits associated with access to reproductive health services. *See citations supra.*

NCDHHS is charged with licensing of hospitals and certification of clinics that provide abortion; denial, suspension, and revocation of facility certifications; and investigations of complaints relating to clinics that provide abortion. *See* Compl. [DE 1], ¶ 17; Answer of Kody H. Kinsley [DE 41], ¶ 17; *see also, e.g.,* N.C. Gen. Stat. § 14.45.1(a1); 10A N.C.A.C. §§ 14E .0101 *et seq*. NCDHHS believes that it is crucial to the promotion of public health and reproductive health to follow the FDA's expert judgment on the conditions that are necessary to balance drug safety, efficacy and access to mifepristone, including

[7] *See North Carolina Maternal Mortality Review Report*, Dec. 2021, at 13, https://wicws.dph.ncdhhs.gov/docs/2014-16-MMRCReport_web.pdf (Last accessed Apr. 27, 2023).

those in the FDA's 2023 modification of the Risk Evaluation and Mitigation Strategy. Compl., ¶ 69; Answer of Kody H.Kinsley, ¶ 69; *see also* 21 U.S.C. § 355-1(a)(1) & (f).

Within the applicable law, NCDHHS will do everything it can to safeguard access to reproductive health services. This is consistent with the FDA REMS requirements that the restrictions on mifepristone must not be "unduly burdensome on patient access to the drug" and must seek to "minimize the burden on the health care delivery system," 21 U.S.C. § 355-1(f)(2)(A), (C), (D). It is equally consistent with the agency's mandate from the General Assembly. *See* N.C. Sess. Law 2013-366(4)(c) (directing NCDHHS to "ensure that standards for clinics certified by the Department address the on-site recovery phase of patient care at the clinic, protect patient privacy, provide quality assurance, and ensure that patients with complications receive the necessary medical attention, while not unduly restricting access.") (emphasis added).

Respectfully submitted, this 28th day of April, 2023.

/s/ Michael T. Wood
Michael T. Wood
Special Deputy Attorney General
N.C. Bar No. 32427

N.C. Dept. of Justice
P.O. Box 629
Raleigh, NC 27602
Phone: 919-716-0186
Fax: 919-716-6758
Email: MWood@ncdoj.gov

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing response complies with Local Rule 7.3(d) because, excluding the parts of the brief exempted by Rule 7.3(d) (cover page, caption, signature lines, and certificates of counsel), this brief contains fewer than 6250 words.

/s/ Michael T. Wood
Michael T. Wood
Special Deputy Attorney General
N.C. Bar No. 32427

N.C. Dept. of Justice
P.O. Box 629
Raleigh, NC 27602
Phone: 919-716-0186
Fax: 919-716-6758
Email: MWood@ncdoj.gov