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Committee on Energy & Commerce, Health Subcommittee

Hearing
Women's Health Protection Act (H.R. 2975)

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Chairwoman Eshoo, Ranking Member Burgess, and Members of the Subcommittee, thank you for the opportunity to testify in support of this important piece of legislation.

My name is Nancy Northup and I am President and CEO of the Center for Reproductive Rights. We are a nonprofit, nonpartisan legal organization working to ensure that reproductive rights are protected as fundamental human rights around the world. I have led the Center for seventeen years, but I have been an advocate for abortion rights for far longer than that. As I look back over the last four decades, I am more concerned today than I have ever been about the attacks on access to abortion care.

Our Constitution protects the right of each of us to chart our own life path and to make the deeply personal decisions that impact our lives, our families, and our health, including whether and when to become a parent. One in four women in the United States will make the decision to have an abortion in the course of her life.¹ Yet in large parts of the United States, obtaining abortion care is difficult—and in some cases, impossible—due to a coordinated, nationwide strategy to eliminate access to abortion care.

Anti-abortion rights lawmakers in state legislatures are doing whatever they can to ensure that patients face insurmountable barriers to care and that clinics are forced to close—effectively banning abortion without ever having to touch *Roe v. Wade*.² Since 2011, nearly 450 laws restricting and banning abortion care have been pushed through state legislatures.³ These laws close clinics, increase health care costs, exacerbate inequalities, and harm women and their families.

In 1992, the year that *Planned Parenthood v. Casey*⁴ was decided, there were 2,380 clinics in the United States. In 2017, there were 1,587—a decrease of one third.⁵ Already, six states are down

¹ Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107(12) AM. J. PUB. HEALTH 1904, 1908 (2017), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304042>.

² *Roe v. Wade*, 410 U.S. 113 (1973).

³ CENTER FOR REPRODUCTIVE RIGHTS, *What if Roe Fell* (2019), <https://reproductiverights.org/what-if-roe-fell>.

⁴ *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

⁵ Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services In The United States, 1991 and 1992*, 26(3) FAMILY PLANNING PERSPECTIVES 100-106 (1994), <https://www.ncbi.nlm.nih.gov/pubmed/8070545> (finding that in 1992, there were 2,380 facilities providing abortion); Rachel K. Jones, Elizabeth Witwer, & Jenna Jerman, *Abortion*

to one abortion clinic⁶ and nearly 90 percent of American counties are without a single abortion provider.⁷ The harms caused by the decimation of abortion access are deeply unequal, falling most heavily on marginalized and underserved people and communities who already experience significant structural and systemic barriers to accessing quality health care including abortion. These communities include low-income people, people of color, immigrants, young people, and people living in rural and other medically underserved areas.

The Women’s Health Protection Act⁸ would ensure that the right to abortion first recognized nearly fifty years ago in *Roe v. Wade* is a day-to-day reality for people in the United States, no matter what state they happen to live in. This bill would create a federal statutory right for providers to provide abortion services, and a corresponding right for their patients to receive abortion services, free from medically unnecessary restrictions and bans that single out abortion and impede access to care.

Congress has the authority under the Commerce Clause to regulate health care as interstate commerce, and the authority under Section 5 of the Fourteenth Amendment to protect against the abridgement of constitutionally protected rights. It must exercise this authority now and protect the right to access abortion care first recognized in *Roe* by passing the Women’s Health Protection Act.

I. The U.S. Constitution Protects Access to Abortion as a Fundamental Right.

The Supreme Court has repeatedly recognized that the Constitution’s protections of liberty must include the right to make intimate decisions and profoundly important life choices about family, relationships, bodily integrity, and autonomy. Abortion sits within that set of essential rights—rooted in decades of interwoven legal decisions protecting liberty and privacy, including the right of parents to direct their children’s upbringing and education, and the right to contraception. These protections are integral to the liberty decisions that followed, including recognition of the

Incidence and Service Availability in the United States, 2017, GUTTMACHER INSTITUTE (Sept. 2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017> (finding that in 2017, 1,587 health care facilities were known to provide abortions).

⁶ Holly Yan, *These 6 States Have Only 1 Abortion Clinic Left*, CNN (May 29, 2019), <https://www.cnn.com/2019/05/29/health/six-states-with-1-abortion-clinic-map-trnd/index.html>.

⁷ Rachel K. Jones, Elizabeth Witwer, & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2017*, GUTTMACHER INSTITUTE (Sept. 2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.

⁸ Women’s Health Protection Act of 2019, H.R. 2975, 116th Cong. (2019). The Women’s Health Protection Act is named in an acknowledgement that women have historically been disproportionately targeted and impacted by laws that restrict abortion and comprehensive reproductive care. However, the text of the bill recognizes that “not all people who become pregnant or need abortion services identify as women. Access to abortion services is critical to the health of every person regardless of actual or perceived race, color, national origin, immigration status, sex (including gender identity, sex stereotyping, or sexual orientation), age, or disability status. This Act’s protection is inclusive of all pregnant people.”

right of same-sex couples to marry.⁹ Weakening the right to abortion would weaken what liberty means for everyone.

Almost fifty years ago, the Supreme Court recognized the Constitution's Fourteenth Amendment's liberty protections encompass the right to make deeply personal decisions about whether and when to become a parent. The landmark decision *Roe v. Wade*, 410 U.S. 113 (1973), held that the right to end a pregnancy is fundamental to a woman's personal liberty.¹⁰

The Supreme Court has repeatedly reaffirmed *Roe*'s central holding, recognizing that a woman's control over her own reproductive decisions is essential to her health, liberty, dignity, and autonomy. In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), the Supreme Court explained that "the ability of women to participate equally in the economic and social life of the nation has been facilitated by their ability to control their reproductive lives."¹¹ In their analysis, the *Casey* Court recognized that, for decades, women have made deeply personal decisions about their lives and their relationships "in reliance on the availability of abortion."¹²

Likewise, in 2016, the Court again upheld the fundamental right to abortion in *Whole Woman's Health v. Hellerstedt*, 36 S. Ct. 2292 (2016), striking down a pretextual law intended to close clinics as unconstitutionally restricting patients' access to abortion. In its opinion, the Court made clear that the undue burden standard is a robust check on legislatures that requires courts to examine closely whether abortion restrictions have actual medical benefits that outweigh the real-world burdens they impose on pregnant people, and strike the restrictions if they fall short.

Yet even while we are winning cases, and courts are striking down these laws as unconstitutional, anti-abortion rights legislators continue to enact unjustified and burdensome regulations. On March 4th, 2020, the Center for Reproductive Rights will be returning to the Supreme Court in *June Medical Services, LLC v. Gee* to challenge a Louisiana law that is identical to the Texas law declared unconstitutional in the *Whole Woman's Health v. Hellerstedt* decision just four years ago.¹³ That is why a federal safeguard like the Women's Health Protection Act is needed. Without federal statutory protections for providers and their patients, the ability of people across the nation to make fundamental personal decisions about

⁹ Amy Myrick, *Roe and Intersectional Liberty Doctrine*, CTR. FOR REPRODUCTIVE RIGHTS (2018), <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Liberty-Roe-Timeline-spread-forweb.pdf>.

¹⁰ *Roe*, 410 U.S. at 155, 153.

¹¹ *Casey*, 505 U.S. at 835.

¹² *Casey*, 505 U.S. at 856.

¹³ *June Medical Services L.L.C. et al. v. Dr. Rebekah Gee* - U.S. Supreme Court Case No. 18-1323 / No. 18-1460.

their bodies, health, and families will remain under attack.

II. Hundreds of Anti-Abortion State Laws Are Substantively Burdening Access to Abortion.

a. States are passing unconstitutional restrictions on abortion access, designed to eliminate access to care, at an alarming rate.

For the past decade, anti-abortion rights lawmakers and activists have engaged in a coordinated, nationwide strategy to burden abortion providers and their patients, fueling an unending cycle of harmful state laws and court fights that follow. These relentless and increasing attacks on abortion care are designed to ensure that providers and patients will face insurmountable barriers and clinics will be forced to close—depriving people of the right to make the most fundamental decisions about their own reproductive health and lives.

Since 2011, nearly 450 laws restricting and banning abortion care have been pushed through state legislatures.¹⁴ In 2018 alone, states introduced almost two hundred bills restricting abortion; twenty-eight of these bills, totaling forty-four restrictions, were enacted.¹⁵

The widespread and deliberate disregard for the constitutional right to abortion escalated even further during the 2019 state legislative sessions, as hostile state lawmakers took new steps to reduce the availability of abortion services. Eighteen states enacted forty-six laws that prohibit or restrict abortion, including laws that force patients to undergo medically unnecessary and invasive medical procedures; impose costly waiting periods; require doctors to lie to their patients; place onerous restrictions on providers; and ban abortion outright.

In 2019, nine states unconstitutionally banned abortion in blatant violation of longstanding Supreme Court precedent,¹⁶ spurring waves of protests across the country.¹⁷ The laws included a total ban on abortion in Alabama; bans on abortion after six-weeks, before many people even know they are pregnant, in Georgia, Kentucky, Louisiana, Mississippi, and Ohio; an eight-week ban in Missouri; and the eighteen-week bans enacted in Arkansas and Utah.¹⁸

Every federal court considering a law prohibiting abortions before viability on its merits, with or without exceptions, has ruled that it violates the Fourteenth Amendment.¹⁹ Yet lawmakers

¹⁴ CTR. FOR REPRODUCTIVE RIGHTS, *What if Roe Fell* (2019), <https://reproductiverights.org/what-if-roe-fell>.

¹⁵ CTR. FOR REPRODUCTIVE RIGHTS, *Protect, Defend, Extend: 2018 State of the States* (Jan. 2, 2019), <https://reproductiverights.org/State-of-the-States-2018>.

¹⁶ CTR FOR REPRODUCTIVE RIGHTS, *What if Roe Fell* (2019), <https://reproductiverights.org/what-if-roe-fell>.

¹⁷ Laurel Wamsley, *Across The Country, Protesters Rally To Stop States' Abortion Bans*, NPR (May 21, 2019), <https://www.npr.org/2019/05/21/725410050/across-the-country-protesters-rally-to-stop-states-abortion-bans>.

¹⁸ CTR FOR REPRODUCTIVE RIGHTS, *What if Roe Fell* (2019), <https://reproductiverights.org/what-if-roe-fell>.

¹⁹ Further, the Supreme Court has affirmed the decision below or denied certiorari in each one of those cases it has been asked to review. *See MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 773 (8th Cir. 2015) (striking down ban on previability abortions at 6 weeks with exceptions), *cert. denied*, 136 S. Ct. 981 (2016); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (striking down ban on previability abortions at 12 weeks with exceptions), *cert. denied*, 136 S. Ct. 895 (2016); *Isaacson v. Horne*, 716 F.3d 1213, 1217 (9th Cir. 2013) (striking down ban on previability abortions at 20 weeks with exceptions), *cert. denied*, 134 S. Ct. 905 (2014); *Jane L. v. Bangerter*, 102 F.3d 1112,

continue to fast-track this unconstitutional legislation in hopes of ending abortion across the United States. This intent is overt: just last November, when a federal district court struck down Mississippi’s ban on abortion after 15 weeks of pregnancy as “unequivocally” unconstitutional, it found that “[t]he State chose to pass a law it knew was unconstitutional to endorse a decades long campaign, fueled by national interest groups, to ask the Supreme Court to overturn *Roe v. Wade*.”²⁰

In another extreme example of harmful state restrictions on abortion access, some states have explicitly mandated that providers give medically inaccurate information to their patients. In 2019 alone, four states—Kentucky, Nebraska, North Dakota, and Oklahoma—passed laws forcing providers to falsely counsel their patients that it is possible to “reverse” the effects of a medication abortion.²¹ The American College for Obstetricians and Gynecologists (ACOG) has stated that these laws recklessly attempt to codify “unproven, unethical research” that endangers patient health;²² the American Medical Association (AMA) filed a lawsuit against the North Dakota law and succeeded in having it blocked.²³ Yet despite this opposition from the medical community, these types of laws remain in effect in six states, forcing providers to lie to their patients and instilling distrust in the sanctity of the doctor-patient relationship.²⁴

The systematic, sustained effort by lawmakers across the country to chip away at the right to abortion incrementally, restriction-by-restriction, has now reached a crisis point. As a result of the outsized efforts of state lawmakers to undermine and eliminate abortion access, there has been a drastic reduction in the availability of health care services across vast swaths of our country. Today, nearly 90 percent of American counties are without a single abortion provider,²⁵ and six states are down to their last abortion clinic.²⁶ More than twenty-seven cities across the

1114, 1117-18 (10th Cir. 1996) (striking down ban on previability abortions at 22 weeks with exceptions), *cert. denied*, 520 U.S. 1274 (1997); *Sojourner T. v. Edwards*, 974 F.2d 27, 29, 31 (5th Cir. 1992) (striking down ban on all abortions with exceptions), *cert. denied*, 507 U.S. 972 (1993); *Guam Soc’y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368-69 (9th Cir. 1992) (same), *cert. denied*, 506 U.S. 1011 (1992); *In re Initiative Petition No. 395, State Question No. 761*, 286 P.3d 637, 637-38 (Okla. 2012) (invalidating proposed definition of a fertilized egg as a “person” under due process clause), *cert. denied*, 133 S. Ct. 528 (2012); *In re Initiative Petition No. 349, State Question No. 642*, 838 P.2d 1, 7 (Okla. 1992) (striking down proposed abortion ban with exceptions), *cert. denied*, 506 U.S. 1071 (1993).

²⁰ *Jackson Women's Health Org. v. Currier*, 349 F. Supp. 3d 536 (S.D. Miss. 2018).

²¹ GUTTMACHER INSTITUTE, *State Policy Trends 2019: A Wave of Abortion Bans, But Some States are Fighting Back* (Dec. 2019), <https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back>.

²² The American Congress of Obstetricians and Gynecologists, *Facts Are Important: Medication Abortion “Reversal” Is Not Supported by Science* (August 2017), <https://www.acog.org/-/media/Departments/Government-Relations-and-Outreach/FactsAreImportantMedicationAbortionReversal.pdf>

²³ Order Granting Pls.’ Mot. Prelim. Inj., *AMA et al. v. Stenehjem, et al.*, No. 1:19-cv-00125-DLH-CRH (D.N.D. Sept. 9, 2019).

²⁴ GUTTMACHER INSTITUTE, *Counseling and Waiting Periods for Abortion*, <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion> (last visited Feb. 9, 2020).

²⁵ GUTTMACHER INSTITUTE, *Data Center: Number of clinics providing abortion by state*, <https://data.guttmacher.org/states> (last visited Feb. 9, 2020).

²⁶ Holly Yan, *These 6 States Have Only 1 Abortion Clinic Left*, CNN (May 29, 2019), <https://www.cnn.com/2019/05/29/health/six-states-with-1-abortion-clinic-map-trnd/index.html>.

country are “abortion deserts,” where patients must travel 100 miles or more to reach an abortion facility.²⁷

With the volume of restrictions, and the widespread reduction in access, it is not enough to rely on constitutional challenges. Even when clinic closure laws are eventually blocked in court, abortion restrictions can have a sweeping and devastating impact on access. Before Texas’ clinic shutdown law was struck down by the Supreme Court in *Whole Woman’s Health*, more than half of the state’s 41 facilities providing abortion care closed, many as a direct result of the restrictions.²⁸ Four years later, Texas women continue to pay the price for Texas politicians’ anti-abortion bias—only three of these clinics have managed to reopen.²⁹

As a result of all these state laws and related clinic closures, the ability to access abortion care today depends on where you live. There are large parts of the country where it is extraordinarily difficult, and in some cases virtually impossible, to access abortion services. For pregnant people in these parts of the country, the constitutional right to abortion is merely theoretical. And when individuals lack access to abortion services, they are harmed.

b. Medically unnecessary abortion restrictions and bans harm patients, with disproportionate impacts on historically marginalized and underserved communities.

Abortion is one of the safest medical procedures and, like all medical care, is subject to laws, regulations, and standards.³⁰ In fact, according to a 2018 independent report from the National Academies of Sciences, Engineering, and Medicine, the biggest threats to the quality of abortion care are *state regulations* that negatively impact the timeliness, efficiency, equity, and patient-centeredness of health care delivery.³¹ The report concluded that restrictions, including admitting privileges, mandatory waiting periods, required ultrasounds, and mandatory provision of misinformation about abortion care, are not medically necessary.³² Instead of fulfilling a purported medical need, the actual effects of these laws are that they delay access to care, increase costs for patients, and burden providers to the extent that they are forced to stop providing abortion care or close clinics altogether.

The broader medical community, and particularly the American Medical Association and the American College of Obstetricians and Gynecologists, has consistently opposed such laws as harmful to the public health, and strongly oppose legislative interference in the practice of

²⁷ Alice F. Cartwright et al., *Identifying National Availability Of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20(5) J MED INTERNET RES e186 (2018), <https://www.jmir.org/2018/5/e186/>.

²⁸ Caitlin Gerdts et al., *Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas*, 106(5) AM. J. PUB. HEALTH 857-64 (2016), doi:10.2105/AJPH.2016.303134.

²⁹ David Yaffe-Bellany, "Five years after Wendy Davis filibuster, Texas abortion providers struggle to reopen clinics", The Texas Tribune, 2018, <https://www.texastribune.org/2018/06/25/five-years-after-wendy-davis-filibuster-abortion-clinics/> (last visited February 10, 2020).

³⁰ National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, Washington, DC: THE NATIONAL ACADEMIES PRESS (2018), <https://doi.org/10.17226/24950>.

³¹ *Id.*

³² *Id.*

medicine. An AMA issue brief entitled “Keeping politics out of the exam room: Protecting the patient-provider relationship” discusses the “alarming number of states introduc[ing] legislation that attempt[s] to prescribe or proscribe the content of information exchanged between physicians and their patients.”³³ This brief raises specific concerns about bills that prohibit providers from speaking to patients about abortion, stating “[t]hese legislative forays into the practice of medicine not only infringe on physicians’ First Amendment right to free speech, they potentially put physicians in an untenable position of risking disciplinary proceedings, criminal prosecution or abandoning ethical obligations to foster patient autonomy.”³⁴ Similarly, ACOG’s Statement of Policy 2016 clearly states:

The patient-physician relationship is essential to the provision of safe and quality medical care and should be protected from unnecessary governmental intrusion. . . . Laws should not interfere with the ability of physicians to determine appropriate treatment options and have open, honest and confidential communications with their patients. Laws that require physicians to give, or withhold, specific information when counseling patients, or that mandate which tests, procedures, treatment alternatives or medicines physicians can perform, prescribe, or administer are ill-advised. Examples of such problematic legislation include. . . laws that require medically unnecessary ultrasounds before abortion and force a patient to view the ultrasound image; laws that mandate an outdated treatment protocol for medical abortion, and laws that prescribe what must be communicated to patients about breast density and cancer risk, contrary to current evidence-based scientific data and medical consensus.³⁵

In December 2019, the AMA and ACOG joined the American Public Health Association and other major medical groups to file an amicus brief in *June Medical Services v. Gee* calling on the Supreme Court to block Louisiana’s clinic shutdown law. The amicus brief states that abortion is extremely safe and that “nationwide, patients are harmed by medically unnecessary restrictions on abortion clinicians.”³⁶

When clinics close, communities also lose additional critical health care services that may have been provided at that clinic, such as contraceptive care and screenings for cervical cancer and sexually transmitted infections. For example, in 2011, Texas excluded Planned Parenthood clinics from family planning reimbursements and in 2013, the state enacted H.B. 2, an omnibus abortion bill containing multiple clinic closure laws. Between 2012 and 2014, the number of

³³ Public Health Improvement. American Medical Association. Available at: <https://www.ama-assn.org/delivering-care/public-health/public-health-improvement>.

³⁴ *Id.*

³⁵ Legislative Interference with Patient Care, Medical Decision, and the Patient Physician Relationship. *American College of Obstetricians and Gynecologists Statement of Policy* 2016. Available at: <https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Legislative-Interference?IsMobileSet=false>

³⁶ Brief of Amici Curiae American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics et al. in Support of June Medical Services L.L.C, et. al., *June Med. Servs. L.L.C. v. Gee*, Nos. 18-1323 & 14-1460, at 4. (U.S. Dec. 2, 2019).

abortion providers in Texas shrank from 42 to 18.³⁷ In 2016, the New England Journal of Medicine assessed rates of contraceptive-method provision, method continuation through the program, and childbirth covered by Medicaid before and after the Planned Parenthood exclusion.³⁸ The study found that “after Texas abruptly excluded Planned Parenthood affiliates from its fee-for-service family-planning program, the number of claims for LARC methods declined, as did the number of claims for contraceptive injections. Among women using injectable contraceptives, fewer women who received an injection in the quarter preceding the exclusion continued to receive an injection through the program than did those in an earlier cohort.”³⁹

Clinic closure also leads to overcrowding at remaining providers. A 2019 study reviewing the impact of Texas’ H.B. 2, determined that the law’s provisions that resulted in the closure of half of the state’s abortion facilities created provider shortages that delayed Texas women in their efforts to access abortion care.⁴⁰ These findings show that restrictive abortion laws reduce women’s access to care and unnecessarily delay their abortion care.⁴¹

Moreover, abortion restrictions impose logistical and financial burdens on patients. A person seeking care must often take extra time away from work and find and pay for additional childcare, transportation, and lodging. To cover these costs, low-income patients may be forced to forgo basic necessities, like food and rent, or borrow money.⁴²

Abortion-specific restrictions interfere with women’s liberty and equality and reinforce stereotypes about women’s roles in society, decision-making capacity, and need for special protection. Further, being denied an abortion can have serious consequences for a woman’s health and well-being, and that of her family. According to a recent longitudinal study, a woman denied abortion care is at increased risk of experiencing poverty, physical health impairments, and intimate partner violence.⁴³ She has an increased likelihood of struggling to pay for basic

³⁷ Danielle Paquette, *After Planned Parenthood closures, poor women started having more babies*, Washington Post (Feb. 5, 2016) <https://www.washingtonpost.com/news/wonk/wp/2016/02/05/after-planned-parenthood-closures-poor-women-started-having-more-babies/>.

³⁸ Amanda J. Stevenson et al, *Effect of Removal of Planned Parenthood from the Texas Women’s Health Program*, N. Engl. J. Med. 2016; 374:853-860, <https://www.nejm.org/doi/full/10.1056/NEJMsa1511902>

³⁹ *Id.*

⁴⁰ White K, Baum S, Hopkins K, Potter JE, and Grossman D. Change in second-trimester abortion after implementation of a restrictive state law. *Obstetrics & Gynecology* 2019; 133(4):771-779.

⁴¹ *Id.*

⁴² Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23(3) WOMEN’S HEALTH ISSUES e173-178 (2013), available at <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2013.03.001.pdf>.

⁴³ Diana Greene Foster et al., *Socioeconomic outcomes of women who receive and women who are denied wanted abortions*, 108(3) AM. J. PUB. HEALTH 407-413 (2018); *Advancing New Standards in Reproductive Health, Turnaway Study: Long-Term Study Shows that Restricting Abortion Harms Women*, BIXBY CENTER FOR GLOBAL REPRODUCTIVE HEALTH (retrieved from https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf).

family needs like food and housing, and her children are more likely to live below the Federal Poverty Line.⁴⁴

The harms these barriers create are deeply unequal, falling most heavily on marginalized and underserved people and communities, especially those with least economic means. Low-income people, people of color, young people, immigrants, people with disabilities, people who live in rural communities, and LGBTQ people already experience significant barriers to accessing quality health care. For example, as reported in a recent issue brief by the National Partnership of Women and Families and In Our Own Voice: National Black Women’s Reproductive Justice Agenda, Black women are more likely to be exposed to negative social determinants of health; they experience higher rates of poverty, homelessness and housing insecurity, food insecurity and unreliable transportation⁴⁵—all factors that are at least partially responsible for racial disparities in birth outcomes.⁴⁶ Likewise, according to the U.S. Department of Health and Human Services (HHS) Healthy People 2020 Initiatives, “LGBT individuals face health disparities related to societal stigma, discrimination, and denial of their civil and human rights.”⁴⁷

Many people experience discrimination due to multiple, intersecting identities (for instance, low-income people of color who are also transgender or disabled) that compound and intensify barriers to accessing abortion care. Discriminatory limitations on public insurance coverage of abortion continue to severely limit abortion access for low-income people and others who receive their health coverage or care through the federal government. The Women’s Health Protection Act does not fix all of these problems. In order for abortion care to be truly accessible it must not be conditioned by a person’s economic circumstances, status or identity. The Women’s Health Protection Act therefore works hand-in-hand with bills such as the EACH Woman Act (S.758/H.R. 1692), a federal bill to eliminate discriminatory coverage restrictions on abortion care, including the Hyde Amendment.⁴⁸ Together these bills have the power to transform access to abortion care across the country.

III. The Women’s Health Protection Act (H.R. 2975) Will Ensure Equal Access Across the Nation.

Recently, we have heard calls across the country to “codify *Roe*” as shorthand for a federal bill that would protect a person’s ability to access abortion, regardless of their zip code. The

⁴⁴ Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term*, 205 J. PEDIATRICS 183-189 (2019), [https://www.jpeds.com/article/S0022-3476\(18\)31297-6/fulltext](https://www.jpeds.com/article/S0022-3476(18)31297-6/fulltext).

⁴⁵ NAT’L PARTNERSHIP FOR WOMEN & FAMILIES & IN OUR OWN VOICE: NAT’L BLACK WOMEN’S REPRODUCTIVE JUSTICE AGENDA, *Maternal Health And Abortion Restrictions: How Lack Of Access To Quality Care Is Harming Black Women* (Oct. 2019), <https://www.nationalpartnership.org/our-work/resources/repro/maternal-health-and-abortion.pdf>.

⁴⁶ *Id.*

⁴⁷ U.S. DEPT. OF HEALTH & HUMAN SERVS, *LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH*, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last visited Feb. 9, 2020).

⁴⁸ Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act, H.R. 1692, 116th Congress (2019).

Women’s Health Protection Act is the legislative solution we need to address the growing disparity in access.

The Women’s Health Protection Act would protect abortion access from the wave of increasingly punitive state-level laws, like Alabama’s near-total ban, that prevent people from making personal decisions about their health, their lives, and their futures. H.R. 2975 creates a statutory right for health care providers to provide care, and a corresponding right for their patients to receive care, free from medically unnecessary limitations and bans that single out abortion and impede access to services.

The Women’s Health Protection Act identifies a specific set of restrictions that would constitute a violation of statutory right, including unconstitutional pre-viability abortion bans, requirements that providers give their patients medically inaccurate information before or during an abortion, and medically unnecessary tests and procedures. The Act also lays out a set of criteria that courts must consider in determining whether a restriction violates the statutory right to abortion, including whether the restriction singles out abortion to treat differently from medically comparable procedures or services and impedes access to care. Finally, the bill creates an enforcement mechanism through both a public and private right of action, similar to many civil rights and anti-discrimination laws.

In short, the bill does more than simply “codify Roe,” by responding in a very specific way to the state-level restrictions that are effectively eliminating access to care today. In that way, the Women’s Health Protection Act can help ensure that the right to abortion first recognized in Roe is a reality.

IV. Congress Has the Power to Protect the Right to Access Abortion Care Across the Nation.

Congress has the authority under Section 5 of the Fourteenth Amendment to pass legislation when state regulations deny or impede the exercise of constitutionally protected rights.⁴⁹ For example, Congress used its power to enact the Voting Rights Act of 1965 to safeguard the right to vote under the Fourteenth and Fifteenth Amendments of the Constitution despite state attempts to prevent people from exercising this right. Congress has explicitly used its Section 5 authority to protect women’s constitutional right to access abortion services and health care providers’ ability to provide abortion services. In 1994, Congress passed the Freedom of Access to Clinic Entrances Act (FACE Act) to protect access to abortion services and to address protests and blockades at health care facilities where abortion services were provided, as well as associated violence.⁵⁰

Further, United State Courts of Appeal have uniformly held that Congress has authority under the Commerce Clause to protect access to abortion.⁵¹ Abortion is a health care service, and abortion restrictions substantially effect interstate commerce in numerous ways expressly laid

⁴⁹ U.S. CONST. amend. XIV, § 5.

⁵⁰ Freedom of Access to Clinic Entrances Act (FACE Act), 18 U.S.C. § 248.

⁵¹ All nine Circuit Courts to address the constitutionality of the Freedom of Access to Clinic Entrances Act held that the Act validly regulated abortion access pursuant to Congress’s Commerce Clause authority. *See Norton v. Ashcroft*, 298 F.3d 547, 556 (6th Cir. 2002) (citing cases).

out in the bill’s findings. Finally, the Necessary and Proper Clause in section 8 of article I of the Constitution, gives Congress the authority to “make all laws which shall be necessary and proper for carrying into Execution” the powers that are vested in it.⁵²

The unprecedented volume of attacks on abortion, and the speed at which these attacks have progressed through the legislative process, requires congressional action. Congress can and must stop the further decimation of reproductive health care and protect the fundamental right to abortion by passing the Women’s Health Protection Act.⁵³

V. Conclusion.

The Center for Reproductive Rights, and other litigating organizations such as the American Civil Liberties Union (ACLU) and Planned Parenthood Federation of America, are fighting to protect abortion rights in constitutional cases across the country. But when our constitutionally protected liberties are under sustained attack, Congress has a responsibility to enact legislation. The Women’s Health Protection Act protects the provision of and access to essential reproductive health care and the constitutional rights of all people, no matter where they happen to live.

We need this law now—because the crisis is now. I urge this committee to send the Act to the floor.

Thank you.

⁵² U.S. CONST. art. I, § 8.

⁵³ Women’s Health Protection Act of 2019, H.R. 2975, 116th Cong. (2019).