Testimony of Jamila Perritt, MD, MPH, FACOG
President and CEO, Physicians for Reproductive Health
before the House Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

Good morning Chairwoman DeLauro, Ranking Member Cole, and distinguished members of the subcommittee. I'm here today on behalf of the patients I care for, in the community I serve every single day – patients who are profoundly impacted by insurance coverage barriers, such as the Hyde Amendment. My name is Dr. Jamila Perritt. I'm a board-certified, fellowship-trained, obstetrician and gynecologist. I have a comprehensive background in family planning and reproductive health, and I am the President and CEO of Physicians for Reproductive Health (PRH), a network of doctors across the country working to improve access to comprehensive reproductive health care. I am also a fellow of the American College of Obstetricians and Gynecologists (ACOG) and chair their Committee on Health Care for Underserved Women. I am here today to talk with you about the people I take care of every day who are working to care for themselves and their communities. Whether they are ready to build or create their family, already parenting, or focused on their education or career, all of the patients I care for share something in common – they are making thoughtful, sometimes difficult, decisions about their health and well-being and they all deserve high quality health care regardless of their income and regardless of where they live.

As this subcommittee is aware, the annual Labor-HHS appropriations bill includes harmful bans on coverage for abortion care, including the Hyde Amendment, which bars health programs under its jurisdiction from covering the cost of abortion care. Named for its author, Representative Henry Hyde (R-IL), the Hyde Amendment primarily withholds abortion coverage from people with low incomes who receive their care through government sponsored health

programs such as Medicaid except in extremely limited circumstances. Hyde-like restrictions have also been added to appropriations language that restricts coverage for federal employees and their dependents, people serving in the military, Peace Corps volunteers, Native American people receiving care through the Indian Health Service, people who are incarcerated in federal prisons and detention centers, people receiving health care from community health centers; survivors of human trafficking who are seeking care through government sponsored programs; and residents of the District of Columbia who are enrolled in Medicaid, despite District voters approving coverage through a ballot measure. The Hyde Amendment is discriminatory. It disproportionately harms people of color, young people, immigrants, and those living in rural areas. What this committee may not know, and why I am here today to discuss, is the real impact of the Hyde Amendment. I am not a legislator, but I am a doctor and I take care of real people who are not able to get the care they need and deserve because of this discriminatory legislation.

I live in and provide care in the District of Columbia, which apart from a brief time in 2011, has been prevented from covering abortion with its local revenue, unlike other states or jurisdictions who are able to provide coverage with their own funds. As an obstetrician and gynecologist, and a front-line provider of health care, I see what happens when women don't have access to health care services because they lack coverage and cannot afford to pay. Abortion services are no different. The Hyde Amendment denies my patients the ability to make decisions about their bodies and their pregnancies entirely because of where they live and how much money they make. More than 177,000 people in the District are federal employees, 7.56 percent of the federal workforce, and are unable to access this essential coverage because they

get their health insurance through the government.[1] When patients find out that their health insurance does not cover abortion, they often experience shock, anger, dismay, and sadness. They feel that they are once more left out of a health care system that was supposed to be designed to support and help them. For the patients I care for, many of whom are living paycheck to paycheck, the cost of reproductive health care and additional expenses such as childcare, transportation, and time away from work can be insurmountable, making access to care impossible. They are placed in the untenable position of deciding whether or not to pay their bills or pull together the funds, time, and resources to access the care they need. Or it may force them to forego an abortion altogether and carry an unwanted pregnancy to term. This is not an insignificant issue. In fact, there is strong medical evidence that shows that when a pregnant person is unable to access the abortion services they want, their lives are profoundly impacted.

The Turnaway study, the largest longitudinal study examining the effects of unintended pregnancy on women's lives, identified serious consequences when people were denied abortion care. Women denied an abortion have four times greater odds of living in poverty.[2] In addition, women denied abortion are: more likely to experience serious pregnancy complications, more likely to stay with abusive partners, more likely to suffer mental health effects such as anxiety, and are less likely to have aspirational life plans for the coming year.[3] As a physician, as a woman, and as a mother myself, I understand the impact that this has on the lives of individuals and their families.

---

[1] *See Policy, Data, Oversight: Federal Civilian Employment*, OPM (Sep. 2017), https://www.opm.gov/policy-data-oversight/data-analysis-documentation/federal-employment-reports/reports-publications/federal-civilian-employment/.

[2] *See* Diana Greene Foster, *Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having – or Being Denied an Abortion*, ANSIRH (2020), https://www.ansirh.org/research/turnaway-study.

[3] *Id.*

Without providing coverage, the safety net patients need to succeed, we continue to support and perpetuate a two-tiered system of health care, dictated by one's income, socio-economic status, and zip code. In the four decades since the Hyde Amendment has passed, we have seen worsening health inequality for Black, Indigenous and other people of color in this country. Health care disparities—manifested by lack of accessible and affordable preventive care such as contraception, pre-conception care, and other preventative health measures—work to maintain these inequities for women of color while rates for other communities continue to fall. For my entire career, over twenty years of providing critical health care, the Hyde Amendment has been used to intentionally limit my ability to give my patients the care they need because of where they live and how much money they earn.

When we examine health outcomes in the context of the COVID-19 pandemic, we see the fundamental inequity present in our health care system and structures. American Indian, Alaskan Native, and Black individuals are five times more likely, and Latinx individuals four times more likely, to be hospitalized for COVID-19 than non-Hispanic white people. Counties with residents who are predominantly Black are also experiencing higher COVID-19 death rates. In addition, people with low incomes are more likely to have comorbidities as a result of systemic and structural racism and inequity, including diabetes and hypertension, that make COVID-19 more deadly. And almost three quarters of workers who are undocumented are currently working in essential roles and are placed at a higher risk of contracting COVID-19.[4] Disappointingly, states have also used COVID-19 as an excuse to restrict or eliminate abortion

[4] *See* Harold A. Pollack & Caroline Kelly, *COVID-19 and Health Disparities: Insights from key Informant Interviews*, HEALTH AFFAIRS (Oct. 27, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201023.55778/full/.

care despite the fact that abortion care is in fact medically necessary, time-sensitive, essential health care.[5]

It is my responsibility to be very clear today and say to you: abortion is health care. Public and private insurance coverage of abortion should be comparable to other essential health care services. And abortion should not be singled out for exclusion or have additional administrative or financial burdens placed upon it. The American College of Obstetricians and Gynecologists (ACOG), along with other medical societies, have identified abortion as an essential health care service that requires timely access to care. ACOG also explicitly recommends the elimination of abortion coverage restrictions like the Hyde Amendment to ensure the availability of abortion services to all people regardless of their socio-economic status.[6]

Many factors impact a person's need to have an abortion. All influences on a person's decision-making are valid and under no circumstances should I be asked as a physician to deny care to those who need it simply because unjust policies are creating insurmountable barriers for my patients. I took an oath to provide compassionate care to those who need it and to uphold the tenant of my training as a physician. Coverage bans like the Hyde Amendment stand in the way of that.

---

[5] *See* Laurie Sobel et al., *State Action to Limit Abortion Access During the COVID-19* Pandemic, KFF (Aug. 10, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/. See *also* Jamila Taylor & Jamila Burgess Perritt, *Abortion is Essential Health Care, Including During a Public Health Crisis*, THE CENTURY FOUND. (April 2, 2020), https://tcf.org/content/commentary/abortion-is-essential-health-care-including-during-a-public-health-crisis/?session=1.

[6] *See Committee Opinion No. 815 Increasing Access to Abortion*, ACOG (Dec. 2020), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion; *Joint Statement on Abortion Access During the COVID-19 Outbreak*, ACOG (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak;

When twelve Black women came together in 1994 to dream of a future for reproductive health and rights in this country, they created a broader vision where the lived experiences of historically oppressed communities and individuals are central to the fight for equity and justice. This framework, that we call reproductive justice, is grounded in an understanding of reproductive health, individual agency and autonomy as basic human rights. It means that every person has the human right to have children and to determine the circumstances and conditions under which they give birth; the human right not to have children and to have the information and resources necessary to prevent and end a pregnancy; the human right to parent the children they have in safe and sustainable communities, free from violence from the individual or the government; and the human right to bodily autonomy. These rights are indivisible. They are inalienable. Whether we are talking about people with low-incomes, young people, LGBTQIA people, immigrants, or people of color, what I want us all to understand is that no one is making decisions about their reproductive health in a vacuum. Our lives are intersectional – our identities and our lived experiences factor into decisions around contraceptive use, pregnancy, and abortion. Job security, educational levels, neighborhood safety, and more, all factor into the decision-making processes and are intertwined with whether and how they seek care. Many phenomenal reproductive justice leaders carry this important work forward every day, particularly in areas of the country lacking equitable abortion access like the South and the Midwest. Organizers, advocates and activist on the ground know what I am telling you today: coverage restrictions, like the Hyde Amendment not only harm patients, they perpetuate a system of injustice.

Taken as a whole, coverage restrictions make it clear that if you are an individual who has health insurance through the government in need of abortion services and cannot gather the

funds, you may be unable to get care. These policy restrictions, enacted every year into law, tell me that if you are poor, you are less deserving of high-quality care. This is not health care. This is punishment, and it is coercion. You, as lawmakers, have an opportunity to take the steps necessary to ensure all patients are able to access the reproductive health care they need regardless of where they live or how much money they make. I urge you to do so. My patients, and importantly our communities, deserve it.