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BEFORE THE SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS, AND CIVIL LIBERTIES

HEARING ON THREATS TO REPRODUCTIVE RIGHTS IN AMERICA
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Thank you very much for the opportunity to appear before you in these hearings on threats to reproductive rights in America. My name is Melissa Murray. I am a Professor of Law at New York University School of Law, where I teach constitutional law, family law, and reproductive rights and justice and serve as a faculty co-director of the Birnbaum Women's Leadership Network. Prior to my appointment at New York University, I was the Alexander F. and May T. Morrison Professor of Law at the University of California, Berkeley, where I taught for twelve years and served as Faculty Director of the Berkeley Center on Reproductive Rights and Justice and as the Interim Dean of the law school.

In 1973's *Roe v. Wade*, the United States Supreme Court recognized that the Fourteenth Amendment's guarantee of liberty protects a woman's right to determine whether to bear or beget a child. Since then, the Supreme Court has consistently affirmed a woman's right to abortion as an essential aspect of the Constitution's guarantees of liberty and equality. In so doing, the Court has held that states may not restrict the abortion right in ways that are unduly burdensome. More precisely, states may not enact legislation that has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion.

Despite these long-standing precedents, state legislatures have continued to test the Constitution's limits by enacting increasingly restrictive abortion laws. These laws make abortion less accessible and more costly. Ostensibly intended to promote and protect women's health, these laws are part of a larger effort to legislate abortion out of existence through piecemeal attacks.

Recent changes in the composition of the Supreme Court and the lower federal courts have further emboldened those seeking to limit a woman's right to abortion. In the last year, efforts to restrict abortion have taken on a more aggressive and extreme posture, flouting the limits that the Supreme Court has consistently recognized. Those responsible for these laws have made their intentions clear. No longer content to chip away at the abortion right through piecemeal legislation, these more recent laws are an obvious provocation designed to relitigate, and ultimately overturn, *Roe v. Wade.*

As we wait for the courts to decide these numerous cases, people are already being harmed. Individuals who already face barriers to health care and economic security, including communities of color, rural families, and LGBTQ individuals, have been and will be particularly impacted. I urge this Committee to keep these communities in mind as you consider ways to support and protect the constitutional right to abortion.

I. The Constitution's Protection of Personal Liberty, Including Access to Contraception and the Right to Abortion, is Central to Women's Dignity and Equality and to Other Important Rights.

The Fourteenth Amendment guarantees all of us liberty and equality. These guarantees cannot exist without recognition of the dignity afforded every member of society as an autonomous individual. For that reason, the Constitution protects an individual's right to make certain personal decisions about intimacy, marriage, and procreation.

The Supreme Court has specifically recognized that a woman has the right to make her own decision about whether to have an abortion.[1] Indeed, according to the Court "[f]ew decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy than a woman's decision . . . whether to end her pregnancy."[2] The exercise of this right without undue hindrance from the State is essential to a woman's dignity as an individual and her status as an equal citizen.

A woman's reproductive autonomy is rooted in the deeply personal nature of her decisions about bearing children and expanding her family. However, the decision of "whether to bear or beget a child" has ramifications beyond the home and family. As the Court has recognized, women's ability "to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[3]

The Supreme Court's decision in *Roe v. Wade*, recognizing the right to abortion, does not stand on its own; it is part of a long line of cases that recognize the constitutional right to privacy and liberty encompasses personal decisions essential to an individual's dignity and autonomy. These decisions include the right to contraception—first recognized in *Griswold v. Connecticut* (1965)[4]—and the right to procreate—first recognized in *Skinner v. Oklahoma*.[5] The Court relied on these core precedents in deciding *Roe v. Wade*, and in *Carey v. Population Services*, it relied on *Roe* in turn for its central holding that "the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State."[6]

Critically, the right to personal liberty is not limited to reproductive rights. It includes the right to marry, first recognized in *Loving v. Virginia*,[7] and reaffirmed in 2015 in *Obergefell v. Hodges*.[8] It includes the right of parents to direct the upbringing of their children, first recognized in two 1920s cases *Meyer v. Nebraska*[9] and *Pierce v. Society of Sisters*.[10] It includes the right to maintain family relationships, including relationships that go beyond the traditional nuclear family.[11] And *Roe* has also influenced the Supreme Court's decision to recognize the right to form intimate relationships,[12] and the right to personal control of medical treatment.[13]

Roe is inextricably bound to this constellation of privacy and personal liberty rights. If *Roe* is dismantled or otherwise eroded, these other rights are threatened too.

II. The United States Supreme Court Has Consistently Upheld and Protected the Right Recognized in *Roe v. Wade*

For over 45 years—including as recently as 2016—the U.S. Supreme Court has upheld the core principles of *Roe v. Wade*, in case after case. Over that time, a right to abortion has faced numerous threats, and the Court has allowed states to impose some restrictions on the right. But it has never strayed from its core holding that each woman has the right to decide whether to continue a pregnancy before viability.

In *Roe*,[14] the Supreme Court held that the constitutional right to privacy includes a woman's right to decide whether to have an abortion. The Court made clear that the right to privacy is "fundamental," meaning that governmental attempts to interfere with the right are subject to "strict scrutiny."[15] To withstand strict scrutiny, the government must show that its law or policy is necessary to achieve a compelling interest. The law or policy must also be narrowly tailored to achieve the interest and must be the least restrictive means for doing so.

The Court identified those state interests as protecting women's health and protecting the "potentiality" of life.[16] The Court developed a trimester framework to balance the woman's right to abortion against these governmental interests: during the first trimester, the decision must be left completely to the woman and her doctor; during the second trimester, a state could only regulate abortion if necessary to protect a woman's health; in the third trimester, generally after fetal viability, a government could regulate and even ban abortion to further its interest in the potentiality of life, but it must safeguard a woman's life and a woman's health.[17]

In the years after *Roe*, the Court struck down most attempts to restrict the right to decide whether to have an abortion,[18] facilitating a woman's ability to control her reproduction, her health, and indeed the course of her life itself.

However, the Court's 1992 ruling in *Planned Parenthood of Southeastern Pennsylvania v. Casey* gave momentum to the strategy of chipping away at the constitutional right to abortion. In *Casey*, the Court was presented with the question of whether to overturn *Roe*. It did not. Instead, the Court expressly reaffirmed *Roe*'s "essential holding"[19] that the Due Process Clause's guarantee that no individual shall be deprived of "liberty" applies to the decision of whether or not to have an abortion before viability.[20] Although it retained *Roe*'s essential holding, the *Casey* Court announced a new standard of review for abortion restrictions. Instead of "strict scrutiny," the highest standard of review, post-*Casey*, courts must review abortion restrictions under the "undue burden" standard.[21] On this account, states may regulate abortion so long as the regulation does not have the purpose or effect of imposing a substantial obstacle in the path of a woman seeking to terminate a pregnancy. Additionally, the *Casey* Court abandoned the trimester framework, and instead adopted the viability framework and gave more weight to the government's interest in protecting "potential life."

After *Casey*, many state legislatures passed burdensome new restrictions on abortion intended to shame, pressure, and punish women who have decided to have an abortion. The stated intent of these laws was to promote potential life and ensure women's health, but the practical impact was to make it more difficult for women to obtain an abortion.[22]

In 2016, the Court addressed these efforts to make abortion care less accessible, by invalidating some of the most restrictive abortion regulations in *Whole Woman's Health v. Hellerstedt.* In that case, the Court issued a 5-3 ruling holding Texas restrictions that created medically unnecessary, burdensome facility and staffing restrictions to be an unconstitutional undue burden.[23] In concluding that the challenged Texas laws violated the Constitution, the Court emphasized that its finding of an undue burden did not depend on a single finding, but rather from the law's collective impacts. Although only one of the challenged laws had gone into effect in Texas while the litigation was pending, it had the effect of shuttering 54% of Texas facilities—reducing the number of clinics from 41 licensed facilities to 19.[24] A study by the Texas Policy Evaluation Project showed the clinic closures caused the average one-way distance to the nearest abortion provider to increase, and for 44% of this group, the new distance exceeded 50 miles.[25] As the Court noted, the laws posed an undue burden because they had the effect of shuttering clinics, increasing wait times and travel distances, and imperiling women's health.[26]

Further, in invalidating the challenged restrictions, the Supreme Court majority specifically noted that the undue burden standard was not a permissive endorsement of the state's purported rationales. Instead, reviewing courts were obliged to review the state's purported justifications and determine if the challenged restriction were appropriate measures to achieve these legislative ends.[27] In the case of the challenged Texas laws, the Court was emphatically clear that the state had failed to support its supposed "legitimate interest" in promoting women's health with any concrete evidence that the challenged laws served women's health.[28]

In *Whole Woman's Health*, the Supreme Court clarified how *Casey*'s undue burden standard should be applied, and reaffirmed the letter and spirit of *Roe.* It once again made clear that the Constitution guarantees each individual the liberty and autonomy to decide whether to continue a pregnancy before viability, and, for that right to have any meaning, women must have access to abortion in practice.

This decisive rejection of medically unnecessary and unduly burdensome abortion laws in *Whole Woman's Health*, however, has not stopped state legislators from enacting such restrictions or lower courts from upholding them. Additionally, since this landmark ruling in 2016, the composition of the Court has once again changed. The addition of Justices Neil Gorsuch and Brett Kavanaugh suggests that the Court may be less willing to adhere to the tenets of *stare decisis* in reviewing abortion restrictions.

The Court's recent action in *June Medical Services v. Gee* is instructive on this point. In 2018, just two years after *Whole Woman's Health*, the U.S. Court of Appeals for the Fifth Circuit upheld a Louisiana restriction identical to the Texas admitting privileges law struck down in *Whole Women's Health.*[29] The petitioners, a Louisiana clinic, immediately petitioned the Court for review of the Fifth Circuit's decision. While the petition for review was pending, five justices of the Supreme Court voted to temporarily block the Louisiana law from going into effect.[30] If the challenged law went into effect, it would reduce the number of abortion providers in the state of Louisiana to just one.[31] Meaningfully, despite *Whole Women's Health* and other directly applicable precedents, the Court's newest members—Justices Kavanaugh and Gorsuch—would have allowed the Louisiana law to take effect, an action that would have eliminated abortion access for thousands of women across Louisiana.[32]

III. Whether it is Regulated Out of Existence or Overturned Outright, the Right to Abortion is Imperiled

The changed composition of the Supreme Court, and that of federal courts around the country, have emboldened anti-abortion policymakers across the states to pass increasingly prohibitive, deliberately provocative, bans on abortion in hopes that these laws will be challenged all the way to the Supreme Court, prompting a reappraisal, and eventual overruling, of *Roe v. Wade.*

In recent weeks, anti-abortion lawmakers in several states—including Georgia, Louisiana, Alabama, Mississippi, and Missouri—have passed increasingly radical abortion bans, marking a dramatic escalation in the scope and tenor of abortion restrictions.[33] Whereas earlier abortion restrictions sought to undermine the abortion right by making health care services less accessible and more procedurally cumbersome, these most recent laws are more forthright in their aim to launch a frontal attack on *Roe v. Wade.* Buoyed by their sense that the federal judiciary is more amenable to their cause, the proponents of these laws nakedly announce their true intent—to prompt the Supreme Court to overturn *Roe v. Wade.*

The effort reflects the determination by anti-abortion legislators and advocates that now is the moment they have been building towards for over forty-five years. With two of President Trump's nominees pulling the Court further right, the anti-abortion foes consider that their moment really has come to once and for all overturn *Roe v. Wade.* Indeed, Alabama State Representative Terri Collins, who sponsored the Alabama abortion ban, explained that his "bill is about challenging *Roe v. Wade.*"[34] Another supporter of the bill, Alabama State Senator Clyde Chambliss, similarly asserted that the goal was "to go directly to the Supreme Court to challenge *Roe v. Wade.*"[35]

If the Court were to overturn *Roe* outright, the practical effects would be staggering. Women could be criminalized and punished in this country for having an abortion.[36] Twenty-two states would be at high risk for quickly making abortion illegal.[37] Access would erode even further in this country, leaving women living in large areas in the South and Midwest with potentially no legal access at all—a burden that would weigh most heavily on women of color, women struggling to make ends meet, immigrant women, and rural women in these states.

The fact that women would have to flee to other jurisdictions in order to access abortion highlights the degree to which overturning *Roe* would render women reproductive refugees who have been stripped of their dignity and equality as citizens. This would deprive many women of their dignity and autonomy.

Yet even if the Supreme Court did not overturn *Roe* as a formal matter, it could nonetheless uphold restrictive legislation, eviscerating abortion rights *sub rosa* and effectively rendering *Roe*'s protections toothless. This would be the continuation of what we have seen over the last thirty years—abortion opponents' decades-long effort to gut *Roe* by an incremental "death by a thousand cuts."

Since 2011, politicians have passed over 400 new abortion restrictions in 33 states across the country.[38] These restrictions aimed to shut down abortion clinics and restrictions that shame, pressure, and punish women who have decided to have an abortion. Many of these laws restrict access to abortion by making the procedure more difficult or expensive to obtain, including

requirements that a woman undergo a medically unnecessary ultrasound before obtaining an abortion,[39] requirements that a woman wait a significant amount of time before obtaining an abortion,[40] prohibitions on purchasing a comprehensive health insurance plan that includes coverage of abortion,[41] and medically unnecessary and burdensome facility and staffing requirements imposed on abortion clinics.[42]

As we have seen over the last twenty years, this slow and steady strategy is incredibly effective. If the Texas restrictions challenged in *Whole Women's Health v. Hellerstedt* had been upheld, more than 75 percent of abortion clinics in Texas would have closed.[43] And even during the time in which one of the restrictions was in effect, several clinics were forced to close—and most have never reopened. The closure of these clinics has meant that the average one-way distance to the nearest abortion provider has increased four-fold.[44] In this regard, although they were eventually invalidated, the Texas restrictions nevertheless had devastating and irreversible effects on access to abortion and other essential health care.

Texas is not alone in this regard. Over the last ten years, the number of abortion providers and clinics has steadily decreased across the country, in part due to restrictive legislation, aggressive clinic protests, and unnecessary licensing requirements.[45] Currently, six states have only one abortion clinic within its borders.[46]

Critically, these laws go beyond undermining abortion to restrict access to other critical health care services, as clinics providing abortion care also typically provide a range of necessary reproductive health care services. As importantly, these clinics often provide care to underserved communities that are the least likely to have access to other health care providers.[47]

IV. Restrictions on Legal Abortion Will Disproportionally Impact Communities that Already Face Barriers to Health Care, Economic Security, and Social and Political Equality.

State laws that restrict abortion access disproportionately impact individuals struggling to make ends meet, women of color (particularly Black, Latinx/Latina, Asian American and Pacific Islander (AAPI), and Native people), rural women, immigrant women, individuals in the LGBTQ community, parents who already have children, and young people. However, the impact of restrictions on abortion on underserved communities cannot be understood in a vacuum. These communities already face multiple barriers to economic opportunity, health care and reproductive health care in particular. Thus, restrictions on abortion—and associated costs that such restrictions impose—make it difficult, and sometimes impossible, for a person in such communities to obtain an abortion. These restrictions jeopardize an individual's long-term economic security and have a negative impact on a person's equal participation in social and economic life by threatening financial well-being, job security, workforce participation, and educational attainment. In practice, these types of restrictions mean that *Roe* is merely an empty promise, not a reality for many living in these underserved communities.

For these most impacted communities, the consequences of being denied an abortion can be dire. Those who are denied access to abortion care have been found to suffer adverse physical and mental health consequences. For example, women denied abortion care are more likely to experience serious

medical complications during the end of pregnancy.[48] They are also more likely to remain in relationships where interpersonal violence is present and are more likely to suffer anxiety.[49] Further, studies show that a woman who wants to get an abortion but is denied is more likely to fall into poverty than one who is able to obtain an abortion.[50] Therefore, the brutal irony is that those who face the biggest hurdles to health care and income security are the very individuals who will be most harmed by the state laws that restrict or even ban abortion access. And the impact of being denied such care further exacerbates the health and economic insecurity threats they face.

Taken together, the impact of these barriers results in a range of negative health outcomes. Take, for example, the crisis of preventable maternal mortality and morbidity that disproportionately affects Black and Native women. Black women in the United States die from pregnancy-related complications at a rate more than 3 times greater than that for white women, and American Indian and Alaskan Native women die at a rate of 2.5 times greater than that for white women.[51] There is a strong correlation between these negative health outcomes and state support for reproductive rights.[52] Many of the same states that have recently enacted extreme restrictions on abortion, including Louisiana, Georgia, Missouri, and Arkansas, have some of the highest maternal mortality ratios in the United States. Eliminating health care options for pregnant persons in these states will only exacerbate this crisis.

Barriers to health care and reproductive care go hand in hand with economic insecurity. The affordable housing crisis, food insecurity, the lack of clean water, the lack of affordable child care, the wage gap (a gap that widens significantly for women of color), the lack of paid family leave, a stagnant minimum wage, all of these issues lead to and compound economic insecurity for underserved communities across the country. And these barriers have only increased under President Trump, as his administration has engaged in a series of executive actions to undermine income security supports, including food security, housing, and Medicaid. The administration has also specifically targeted low-income immigrants by threatening to jeopardize their immigration status if they seek basic care and public benefits.

Only with a fuller picture of these multiple, intersectional, and compounding barriers to health and economic security can one fully understand the impact of these abortion restrictions on people of color. An individual seeking abortion care in states that have enacted restrictive abortion laws must navigate a state-created obstacle course. Last weekend, the *New York Times* reported on a recent study that found that over 11.3 million women of reproductive age live over an hour from an abortion clinic.[53] That's over two hours round trip. And in many places the travel time is even greater. What if you have kids and cannot get child care at a moment's notice? What if you cannot get the time off work? What if you do not have a car? This is what people are forced to manage, just to exercise their fundamental right to basic health care.

These obstacles are further compounded by the impact of health care insecurity and economic insecurity. Take for example, a woman who works a minimum wage job that provides neither paid leave nor health care. To seek an abortion in a state with a legislatively-imposed waiting period and only one clinic, she must take multiple days off from work at her own expense, identify child care for her children, and pay out of pocket for the abortion and associated travel costs to access a provider. Not surprisingly, these kinds of pressures are a strong deterrent to those seeking abortion care. For undocumented persons, many of whom cannot travel for fear of detention and deportation, there are even fewer options. Similarly, young people may be forced to go through judicial bypass procedures,

forcing them to take additional time to appear in front of a judge before being allowed to access abortion care services—or they may be denied access altogether if a judge does not approve the decision to terminate a pregnancy.

These dire scenarios all show that these structural barriers to health care and economic security heighten the pressures that restrictive abortion laws impose on underserved communities. Indeed, in moving to restrict abortion, anti-abortion legislators make clear that they have no intention of addressing the structural barriers that impair the autonomy, dignity, and equality of these vulnerable communities. Instead, they have pursued a legislative agenda that makes these hardships more grave.

Conclusion

Reproductive rights are imperiled in the United States. Anti-abortion forces have set their sights on overturning *Roe v. Wade* with renewed vigor, confident that they will find a receptive audience in the Supreme Court. But even if the Court declines this invitation to overrule *Roe v. Wade*, unduly burdensome abortion restrictions continue to stymie and strangle access to abortion care. These issues are compounded for our most vulnerable communities.

Women, especially those in underrepresented communities, require government action—not to restrict the constitutional rights to which they are entitled, but to protect this fundamental right and those who seek to exercise it. If state legislators will not abandon their efforts to undermine and overrule *Roe v. Wade*, then Congress must act to secure the right to abortion for all.

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[1] *See* Roe v. Wade, 410 U.S. 113 (1973).
[2] Thornburgh v. Am. College Obstetricians & Gynecologists, 476 U.S. 747, 772 (1986).
[3] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 556 (1992).
[4] 381 U.S. 479 (1965).
[5] 316 U.S. 535 (1942).
[6] Carey v. Population Servs. Int'l, 431 U.S. 678, 687 (1977).
[7] 388 U.S. 1, 12 (1967).
[8] 135 S. Ct. 2584, 2604-05 (2015).
[9] 262 U.S. 390 (1923).
[10] 268 U.S. 510 (1925).
[11] *See, e.g.*, Moore v. East Cleveland, 431 U.S. 494, 500-06 (1977).
[12] *See, e.g.*, Lawrence v. Texas, 539 U.S. 558, 564 (2003).
[13] *See, e.g.*, Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 342 (1990) (Stevens, J., dissenting); Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 71 (1976) (invalidating a requirement that a married woman obtain her husband's consent for an abortion).
[14] 410 U.S. 113 (1973).
[15] *See id.* at 155.
[16] *Id.* at 162.
[17] A case that accompanied *Roe, Doe v. Bolton*, explained that "health" must be understood "in light of all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well-being of the patient. All these factors may relate to health." Doe v. Bolton, 410 U.S. 179, 192 (1973).
[18] *See, e.g.*, Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976) (invalidating a husband consent requirement, requirement that physicians preserve the life and health of the fetus at every stage of pregnancy, and a prohibition on a particular method of abortion); City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416 (1983) (invalidating a

requirement that physicians give women anti-abortion information, a 24-hour mandatory delay requirement, a requirement that all abortions after the first trimester be performed in a hospital, a parental consent requirement, and a requirement related to the disposal of fetal remains).

[19] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 834 (1992).

[20] *Id.* at 846 ("Constitutional protection of the woman's decision to terminate her pregnancy derives from the Due Process Clause of the Fourteenth Amendment…The controlling word in the cases before us is 'liberty.'").

[21] *Id.* at 837.

[22] *See generally* GUTTMACHER INST., AN OVERVIEW OF ABORTION LAWS (May 1, 2019), https://www.guttmacher.org/state-policy/explore/overview-abortion-laws.

[23] *See id.* at 2311-18; *see also* Caitlin Gerdts, Liza Fuentes, Daniel Grossman, Kari White, Brianna Keefe-Oates, Sarah E. Baum, Kristine Hopkins, *Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas,* 106 AM. J. PUBLIC HEALTH 857, 860–63 (2016), https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303134 (discussing survey results from a Texas-resident women assessing travel burdens after the introduction of Texas House Bill 2 in 2013).

[24] Gerdts et al., *supra* note 23, at 857.

[25] *Id.*

[26] *See* Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2316 (2016) ("At the same time, the record provides adequate evidentiary support for the District Court's conclusion that the surgical-center requirement places a substantial obstacle in the path of women seeking an abortion. The parties stipulated that the requirement would further reduce the number of abortion facilities available to seven or eight facilities, located in Houston, Austin, San Antonio, and Dallas/Fort Worth.").

[27] *Id.* at 2310.

[28] *Id.* at 2311 ("We have found nothing in Texas' record evidence that shows that . . . the new law advanced Texas' legitimate interest in protecting women's health.").

[29] June Medical Servs. v. Gee, 905 F.3d 787 (5th Cir. 2018).

[30] June Med. Servs., L.L.C. v. Gee, 139 S. Ct. 663 (2019) (granting stay).

[31] June Medical Servs. v. Gee, 905 F.3d 787 (5th Cir. 2018), *petition for cert. filed*, No. 18-1323, at 2 (U.S. Apr. 17, 2019).

[32] *See* 139 S. Ct. 663 (2019) (Kavanaugh, J., dissenting).

[33] Adam Liptak, *Path to Nullify* Roe v. Wade *a Little Bit at a Time,* N.Y. TIMES, May 16, 2019, at A1.

[34] Emily Wax-Thibodeaux, *Alabama Senate Passes Nation's Most Restrictive Abortion Ban, Which Makes No Exceptions for Victims of Rape and Incest*, WASH. POST (May 14, 2019), https://www.washingtonpost.com/national/alabama-senate-passes-nations-most-restrictive-abortion-law-which-makes-no-exceptions-for-victims-of-rape-and-incest/2019/05/14/e3022376-7665-11e9-b3f5-5673edf2d127_story.html?utm_term=.1fd441c61bc9.

[35] Daniel Trotta, *Alabama Senate Bans Nearly All Abortions, Including Rape Cases*, REUTERS (May 14, 2019), https://www.reuters.com/article/us-usa-abortion-alabama/alabama-senate-bans-nearly-all-abortions-including-rape-cases-idUSKCN1SK13E.

[36] *See* SIA LEGAL TEAM, ROE'S UNFINISHED PROMISE: DECRIMINALIZING ABORTION ONCE AND FOR ALL 1-2 (2018), https://www.sialegalteam.org/roes-unfinished-promise.

[37] *See* CTR. REPROD. RTS., WHAT IF ROE FELL?, https://www.reproductiverights.org/what-if-roe- fell (last updated Feb. 21, 2019) (providing a state-by-state comparison of state laws threatening abortion rights).

[38] Elizabeth Nash et al., Policy Trends in the States, 2017, GUTTMACHER INST. (Jan. 2, 2018), https://www.guttmacher.org/article/2018/01/policy-trends-states-2017.

[39] Eleven states now require women to undergo a medically unnecessary ultrasound before obtaining an abortion. GUTTMACHER INST., *Requirements for Ultrasound* (May 1, 2019), https://www.guttmacher.org/state-policy/explore/requirements-ultrasound.

[40] Twenty-seven states require that a woman wait at least 24 hours between receiving state-mandated counseling and obtaining an abortion. GUTTMACHER INST., *Counseling and Waiting Periods for Abortion* (May 1, 2019), https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion.

[41] Eleven states now prohibit women from buying an insurance plan that includes abortion coverage, except in limited circumstances, in all private insurance plans written in the state. Twenty-six states restrict coverage in the insurance exchanges. GUTTMACHER INST., *Restricting Insurance Coverage of Abortion* (May 1, 2019), https://www.guttmacher.org/state-policy/explore/restricting-insurance-coverage-abortion.

[42] Twenty-four states have laws that contain medically unnecessary facility and/or staffing requirements for abortion providers. GUTTMACHER INST., *Targeted Regulation of Abortion Providers* (May 1, 2019), https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers.

[43] CTR. REPROD. RTS.., *Women's Health Care Providers Ask U.S. Supreme Court to Take On Texas Clinic Shutdown Law* (Sept. 03, 2015), https://reproductiverights.org/press-room/womens-health-care-providers-ask-us-supreme-court-to-take-on-texas-clinic-shutdown-law.

[44] Gerdts et al., *supra* note 23, at 857.

[45] *See generally* Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability In the United States, 2014*, 49 PERSPECTIVES SEXUAL & REPRODUCTIVE HEALTH 17 (2017), https://www.guttmacher.org/sites/default/files/article_files/abortion-incidence-us.pdf (examining the relationship between TRAP laws and decreased abortion service availability nationwide); Rachana Preadhan, Renuka Rayasam, & Mohana Ravindranath, *Even if Roe is Upheld, Abortion Opponents are Winning*, POLITICO (May 30, 2019), https://www.politico.com/story/2019/05/30/abortion-opponents-winning-roe-vs-wade-1488818 (last updated May 31, 2019) (describing the "piecemeal state laws" that have decreased abortion service availability).

[46] Preadhan, Rayasam, & Revindranath, *supra* note 45 ("Six states — Kentucky, Missouri, Mississippi, North Dakota, South Dakota and West Virginia — have only one clinic left that performs abortions[.]").

[47] Women of color have long experienced stark health disparities in areas like cervical and breast cancer, unintended pregnancy, pregnancy-related complications, and burdens to accessing safe abortion. Marcela Howell & Ann Starrs, *For Women of Color, Access to Vital Health Services Is Threatened*, HILL'S CONGRESS BLOG (July 27, 2017), https://www.guttmacher.org/article/2017/07/women-color-access-vital-health-services-threatened.

[48] *See* UNIV. OF CALIFORNIA-SAN FRANCISCO, TURNAWAY STUDY, https://www.ansirh.org/research/turnaway-study [hereinafter TURNAWAY STUDY] (last visited May 31, 2019) (detailing a prospective longitudinal study examining the mental health, physical health, and socioeconomic consequences of unintended pregnancy).

[49] *See* NAT'L WOMEN'S L. CTR., MOVING WOMEN & FAMILIES FORWARD: A STATE ROADMAP TO ECONOMIC JUSTICE 13-14, 53 (2015), https://nwlc.org/wp-content/uploads/2015/02/final_nwlc_2016_StateRoadmapv2.pdf.

[50] *See* NAT'L LATINA INST. REPRODUCTIVE HEALTH, ¡SIN SEGURO, NO MÁS! WITHOUT COVERAGE, NO MORE: LATINXS ACCESS TO ABORTION UNDER HYDE 2 (Oct. 2018), https://latinainstitute.org/sites/default/files/NLIRH_Hyde%20Amendment18_Eng_R3.pdf ("Research shows that one in four low-income women on Medicaid who seek abortion care is unable to afford to pay out-of-pocket cost and is forced to carry the pregnancy to term. A woman who wants to get an abortion but is denied is more likely to fall into poverty than one who can get an abortion."); *see also* TURNAWAY STUDY, *supra* note 48.

[51] Patti Neighmond, *Why Racial Gaps in Maternal Mortality Persist*, NAT'L PUB. RADIO (May 10, 2019), https://www.npr.org/sections/health-shots/2019/05/10/722143121/why-racial-gaps-in-maternal-mortality-persist.

[52] CTR. REPROD. RTS. & IBIS REPROD. HEALTH, EVALUATING PRIORITIES: MEASURING WOMEN'S AND CHILDREN'S HEALTH AND WELL-BEING AGAINST ABORTION RESTRICTIONS IN THE STATES 2017 RESEARCH REPORT 3, 16, 25 (2017), https://reproductiverights.org/sites/default/files/documents/USPA-Ibis-Evaluating-Priorities-v2.pdf.

[53] K.K. Rebecca Lai & Jugal K. Patel, *For Millions of American Women, Abortion Access Is Out of Reach*, N.Y TIMES (May 31, 2019), https://www.nytimes.com/interactive/2019/05/31/us/abortion-clinics-map.html?action=click&module=Top%20Stories&pgtype=Homepage (discussing research from the Advancing New Standards in Reproductive Health project at the University of California, San Francisco).