

THREATS TO REPRODUCTIVE RIGHTS IN AMERICA

HEARING
BEFORE THE
SUBCOMMITTEE ON THE
CONSTITUTION, CIVIL RIGHTS,
AND CIVIL LIBERTIES
OF THE
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HOUSE OF REPRESENTATIVES
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THREATS TO REPRODUCTIVE RIGHTS IN AMERICA

TUESDAY, JUNE 4, 2019

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS,
AND CIVIL LIBERTIES

COMMITTEE ON THE JUDICIARY

Washington, DC.

The subcommittee met, pursuant to call, at 10:09 a.m., in Room 2141, Rayburn Office Building, Hon. Steve Cohen [chairman of the subcommittee] presiding.

Present: Representatives Cohen, Nadler, Raskin, Scanlon, Dean, Garcia, Escobar, Jackson Lee, Johnson of Louisiana, Collins, Gohmert, Cline, and Armstrong.

Also Present: Representatives Chu, Roby, and Lesko.

Staff present: Lisette Morton, Director of Policy, Planning, and Member Services; Madeline Strasser, Chief Clerk; Moh Sharma, Member Services and Outreach Advisor; Susan Jensen, Parliamentarian/Senior Counsel; James Park, Chief Counsel, Constitution Subcommittee; Sophie Brill, Counsel, Constitution Subcommittee; Will Emmons, Professional Staff Member, Constitution Subcommittee; Paul Taylor, Minority Counsel; and Andrea Woodward, Minority Professional Staff Member.

Mr. COHEN. Good morning, everyone. The Committee on the Judiciary Subcommittee on the Constitution, Civil Rights, and Civil Liberties, will come to order. Without objection, the chair is authorized to declare recesses of the subcommittee at any time.

I welcome everyone to today's hearing on threats to reproductive rights in America. I will now recognize myself for my opening statement.

More than 45 years ago, the United States Supreme Court recognized that women must have the right to control their own bodies, including by having the right to decide when to have children and when to terminate a pregnancy. Now, it was not an unlimited right, but it was a right. More than 25 years ago, the Supreme Court affirmed that right after years of sustained opposition.

Now in this year, the year of 2019, the rights of women across the Nation are under attack like never before. It started with a flurry of laws meant to scare and shame women and to regulate abortion providers out of existence. These laws require clinics to offer or perform ultrasounds on women and even to provide medi-

cally inaccurate counseling, counseling dictated by the legislature, not by doctors. They demean women by imposing “waiting periods,” and some, such as my home State of Tennessee, compound the obstacles and red tape by requiring women to travel to a clinic to receive the State’s mandated lecture, written by our general assembly, about her body in person, then undergo a waiting period, and then travel back to the appointment.

Other laws, also enacted under the guise of protecting women, have attempted to shut clinics down by requiring doctors to obtain admitting privileges at nearby hospitals and requiring the clinics to outfit themselves like surgical facilities. Ironically, because abortion is such a low-risk procedure, doctors are often unable to meet the requirements for admitting privileges because few or none of their patients ever require a hospital visit.

In Alabama, as Dr. Yashica Robinson will note, the State passed legislation that require her clinic to relocate to a new facility so that it could meet burdensome new physical requirements. Then when the relocation was complete, the State passed a law to try to chase the clinic away again by prohibiting it from operating next to a nearby school. It was only through the intervention of a Federal judge that the clinic was allowed to stay open.

A few years ago, there was some hope that the Supreme Court’s ruling in *Whole Women’s Health v. Hellerstedt* would put a stop to laws like these. In that case, the Court struck down a Texas law that required doctors providing abortions to obtain admitting privileges at hospitals, and required providers to have the physical capacity of a full surgical facility. The Supreme Court, with Justice Kennedy joining the majority opinion, held that these requirements had no medical benefit for women and would serve only to close down clinics, leading to particularly harsh results for poor women and women in rural communities.

But Justice Kennedy has now been replaced by Justice Kavanaugh, and it now seems that the gloves are off. Many States have dropped the pretense all together that they are somehow trying to protect women. This year alone, Georgia, Kentucky, Mississippi, and Ohio have enacted laws banning abortion once a fetal heartbeat is detected, which occurs approximately 6 months into a pregnancy, before many women even know they are pregnant.

Alabama has enacted a law banning abortion outright with exceptions only in cases where the life of the mother is in danger. There are no exceptions for rape or incest or for women’s health. Missouri has enacted a law banning abortions after 8 weeks, and Arkansas and Utah have enacted laws banning abortions after 18 weeks, all periods in which *Roe v. Wade* protects a woman’s right. Many other States have enacted the so-called trigger laws that would immediately ban abortion if the Supreme Court overturns its decision in *Roe v. Wade*. These States appear to be betting that the Court is about to take that step.

We cannot afford to go back. I would not presume to know what it is like for a woman to live in a world where she has to participate in a crime in order to end a pregnancy that she does not want, or cannot afford to have, or cannot put her body through, or was the result of rape or incest. Americans, Democrats and Republicans, are in strong, strong support of allowing abortion when it

is the result of rape or incest or to protect the life of a woman. And in most of these States' new laws, those exceptions are not written into the law, making it a very, very minor, unpopular, and undemocratic approach.

I do remember what it was like for the women I knew growing up. I remember when a friend of my family needed to get an abortion when it was illegal in the United States, pre-Roe v. Wade. She was relatively lucky. She was wealthy, so she was able to fly across the country to California and go to Tijuana. And it made me realize—I was only 14 or 15 years old—what a poor person would be and the circumstance they would be in. They would be out of luck because they couldn't afford that first-class air ticket or the coach class air tickets. But air tickets were expensive in the 60s, and to go across country and to go to Mexico was an expensive ordeal, which people of means could afford to do. People not of means could not.

This had a disparate impact upon poor women, women of color, women of rural communities who couldn't take the time off or had the money to make that trip. If States are allowed to outlaw access to abortion again, these laws would doubtless have that disparate impact on these groups of women, just as it was when it was illegal before Roe v. Wade.

Women are fighting back. Our witnesses today include two legal experts who are raising awareness of these issues, one of whom is fighting day after day to keep these clinics open. We will also hear from two physicians who provide reproductive healthcare to patients, including abortion care when necessary. And we have two women with the courage to share their own stories about receiving abortions, because they have recognized how important it is to de-stigmatize this subject and stop shaming women for their choices and medical histories. I thank our witnesses for being here today, and I look forward to hearing from each of the women on the panel about this critical and timely subject.

It is now my pleasure to recognize the ranking member of the subcommittee, the gentleman from Louisiana, Mr. Johnson, for his opening statement.

Mr. JOHNSON of Louisiana. Thank you, Mr. Chairman. This is a serious issue, and there may be no more divisive issue in our country than the decades-long battle over the sanctity of human life. Indeed, many Americans regard this as the defining issue of our times.

In Congress, our Pro-Life Caucus and Republican Conference members work hard every day to advance measures to protect more children in the womb because they are the most vulnerable and threatened lives in our society. We do this work because we share the same deep and abiding conviction that so many of the founders of this extraordinary Nation did about the sanctity of human life. It is that seminal conviction, of course, that is recorded in the very birth certificate of our Nation, the Declaration of Independence, and has come to be known as our Nation's creed. You know the language well: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness."

We believe, as the founders articulated, that every single human life is sacred because that value is given to us not by the State, but by our Creator in Whose image all of us are made. Because of this, every single human life has inestimable dignity and value, and our value is not related in any way to the color of our skin, our zip code, our socioeconomic status, our level of talent or education, or what we can contribute to society. Our value is inherent because it is given to us by our Creator.

During the first 2 centuries of our republic, most Americans accepted and revered the biblical truths that every human being is fearfully and wonderfully made, and personally known by our Creator, God, even before they were formed in their mother's womb. The rejection of that essential truth has now led to the murder of more than 60 million innocent pre-born children since 1973's *Roe v. Wade*. What an unspeakable tragedy this is.

In addition to the deeply-held conviction about the lives of the unborn, millions of conscientious Americans also support pro-life legislation and reasonable restrictions on the abortion practice because it is pro-women to do so. The abortion industry itself presents very real dangers for millions who are in difficult circumstances. I bring firsthand knowledge of those dangers to this hearing today. Prior to my election to Congress, I spent a good portion of my 20-year legal career in the courts defending common-sense, pro-life legislation when those laws are challenged, and litigation to protect vulnerable women who were irreparably harmed by the notorious practices of the abortion industry. In fact, I was co-counsel in the trial of one of the cases that the chairman's hearing memo today laments was upheld by the Fifth Circuit in 2018.

Over the course of my career, we uncovered and made public shocking evidence, including the documented use of rusted surgical instruments, filthy and dangerous conditions in the clinics, unlicensed doctors engaging in physical and emotional abuse of patients, falsifying health records, and so much more. I have spent many hours with and conducted extraordinary depositions of abortion providers, some of whom boasted about personally performing tens of thousands of abortions each. Their callous disregard for the barbarism of their practice and the countless precious lives they terminated merely for cash was always stunning to me. To so many of these abortion providers, women are merely objects and a source of revenue, and State health and safety regulations put in place to protect those vulnerable women are mere nuisances to be blatantly ignored. There is no one in this room that can tell me otherwise because I have seen and heard and documented all this in court records myself.

Today we also have indisputable scientific evidence and advanced medical technology, like 4-D ultrasounds, that clearly affirm the humanity of every unborn child. We know that when a human sperm meets and fertilizes a human egg at the moment of conception, there becomes an unborn living, genetically distinct, and biologically self-directed human being. That is an uncontroversial statement among embryologists and those who practice modern medicine generally. In other words, there is no such thing as a potential human being. There are only human beings from the moment of conception.

But today we see lawyers and politicians and activists straining logic and language past the breaking point for political reasons. They do their very best to avoid phrases like “unborn child,” and try to defend and deny the gruesome reality of abortion, which expert witnesses have previously described before this very subcommittee as a typical procedure in which a living human being is literally and brutally ripped to pieces limb by limb. When I served in the Louisiana legislature, I authored and passed a ban on the barbaric dismemberment abortion procedure in my State. Of course, the abortion lobby immediately challenged it in Court.

Over the past several months, we have all witnessed liberals in high political office move aggressively to further expand abortion rights, even after the point when an unborn child can clearly live outside the womb on its own. The United States, by the way, you should know, is one of only seven Nations, including North Korea and China, that allow elective abortions after 20 weeks, a practice that kills thousands of innocent babies every year. New York’s Reproductive Health Act allows all abortions up to 24 weeks and expanded access for later abortions. There is proposed legislation in Virginia, as we all now know, that the bill sponsor said would allow an abortion even during labor, and Virginia Governor Ralph Northam infamously endorsed allowing physicians and mothers to let children die in some circumstances.

When Senate Republicans in this Congress pressed for a vote on the Born Alive Abortion Survivors Protection Act, Federal legislation that the House has passed in previous years that would simply require doctors to provide medical care to babies born alive after failed abortion procedures, incredibly 45 Senate Democrats voted to block its further consideration and passage in the Senate. I stood in the back of the Senate chamber that night with dozens of our Republican colleagues, and we could not believe what we were watching.

Mr. Chairman, this hearing is entitled “Threats to Reproductive Rights in America,” but rights must be accompanied by responsibilities. In this case, that responsibility includes our duty to protect unborn human beings. As the Declaration acknowledges, this is the first and most fundamental obligation of any civilized people.

My own mother had just turned 17 when she and my father decided to choose life and allow me into the world, and I am so grateful that they did. Countless millions of young women have made that same blessed choice, and their children are equally thankful. For women in vulnerable situations who have made the opposite decision and lived to regret it, I just want to say personally that you, too, are valued and loved, and that the Creator, Who gave us our inalienable rights, is so gracious that He offers hope, forgiveness, and redemption to every single one of us.

I look forward to hearing from all of our witnesses here today, and we thank you for your time. Mr. Chairman, I would ask unanimous consent that the full committee members, Mrs. Roby and Mrs. Lesko, be allowed to sit on our subcommittee today.

Mr. COHEN. Without objection, that will be done.

Mr. JOHNSON of Louisiana. Thank you. I yield back.

Mr. COHEN. I want to thank the ranking member for his statement. His positions are different from mine, but they are heartfelt

and they are sincere. And another member who has heartfelt and sincere opinions at least is Mr. Judy Chu of California. She is here, and I want to recognize her for her attendance and her support.

And now I want to recognize the chairman of the full committee, one of the leading voices for many, many years for women's rights and choice and the Constitution, the chairman of the full committee, the gentleman from New York, Mr. Nadler, for his opening statement.

Chairman NADLER. Thank you, Chairman Cohen, for convening this hearing to address the ongoing assault against women's reproductive rights that we are witnessing across the Nation. This country has reached a crisis point for women's constitutional rights to control their own bodies and their own reproductive choices. States have passed unconstitutional bill after unconstitutional bill, imposing new extreme restrictions on abortion, setting the most direct challenge to *Roe v. Wade* we have seen in decades.

In the month of May alone, Alabama outlawed abortion outright, making no exceptions even in cases of rape or incest. Georgia and Louisiana effectively outlawed abortion at just 6 weeks into a pregnancy, and Missouri outlawed abortion just 8 weeks into a pregnancy. These laws would in many instances ban abortions before women even know they are pregnant. Meanwhile, the new conservative majority in the Supreme Court upheld portions of an extreme anti-abortion law from Indiana, and the last abortion clinic in Missouri came to the brink of being forced to close its doors after the State refused to reissue its license. Had the Court not intervened, Missouri would have been the first State, but surely not the last, without a single abortion clinic.

Let me add a word here about some of the rhetoric we have heard already today. The rhetoric from the ranking member of the subcommittee is heartfelt and sincere. It is also arrogant in that it seeks to impose his and certain other people's moral commitments on people who don't share those moral opinions. The power of the State should not be used by one segment of society to impose its moral or religious beliefs on another segment of society. Political power should not be fought over as to who can control other people's religious and moral convictions and the actions stemming therefrom. That is the fundamental question in this whole fight.

After decades of chipping away at the right to an abortion, States now realize that the new conservative majority on the Supreme Court presents an opportunity either to overturn *Roe* completely or to so radically undermine the right to an abortion as to render it essentially meaningless. But the need for a safe, legal abortion will never be meaningless. The right to have an abortion is fundamental to women's equality, autonomy, and personal liberty. Making decisions about when and how to start a family is essential to women's lives and is their decisions, not Congress', not some state legislatures.

As the Supreme Court put it 27 years ago when it upheld *Roe* after nearly 2 decades of challenges, "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." We will not go backward. If women cannot make decisions about their reproductive health, they cannot make decisions about start-

ing a career, going to school, opening a business, and planning their lives. When you restrict access to abortion, you strip women of the fundamental freedom to live life on their own terms.

The last few weeks have seen an all-out frontal attack on the right of every woman in this country to access abortion, but this fight is not new, and these laws have not come out of nowhere. The bans and extreme restrictions and enactments in States like Alabama, Georgia, and Louisiana, as well as in many others, represent some of the most extreme legislation coming from the States. But over the last decade, State legislatures have passed hundreds of bills designed to block women from accessing care and for making their own choices. These laws impose medically unnecessary regulations on doctors and on clinics, right down to the clinics' physical dimensions. Some States have even gone so far as to require women who receive abortions by taking a pill rather than through surgery, to take that pill inside a clinic that must meet the standards of a full surgical facility.

Under the disingenuous claim that these types of laws protect women's health, these States are deliberately attempting to put abortion out of reach, particularly for low-income women and women of color. The result is predictable. Many women will get abortions, illegal abortions, medically unsafe abortions, and the death rate will go up. These laws set arbitrary and unnecessary waiting periods that force women to take extra time off to work and delay care. They require unnecessary tests and biased counseling that do nothing but drive up the cost of abortion care. They set arbitrary regulations for providers that are designed solely to force clinics to close. And, most egregiously, they are designed to intimidate and shame women for making the constitutionally-protected choice to have an abortion.

And this is not only happening in the States. Here in the United States Congress, the Republican-controlled Senate is considered a ban on abortion after 20 weeks, a bill that has no basis in science and is *prima facie* unconstitutional. Meanwhile, the current Administration has taken every opportunity to undermine the right to access abortion and even contraception. It seems every other week the Administration nominates a new-anti-choice Federal judge or official, promulgates yet another rule undermining access to birth control or ending unbiased family planning services, and announces yet another new policy to protect those who discriminate against patients seeking an abortion rather than protecting the patients themselves.

Enough is enough. Congress must now stand up with women and men around the country to say we will not turn back the clock on women's constitutional rights and women's autonomy. It is my hope that today's hearing is Congress' first step to shoring up the right to abortion across this country through legislation like Representative Judy Chu's Women's Health Protection Act, which would put an end to States banning or otherwise limiting access to abortion, and Representative Barbara Lee's Each Woman Act, which would end abortion coverage bans, or other legislative initiatives. We must act to ensure that every woman, regardless of State, income, race, or any other factor, retains her constitutional right to make her own choice and to access abortion. Women must have the

freedom to make decisions about their lives without anyone questioning their intellect, their morals, or their honesty.

I stand with the members of the committee and millions of women and men around this country ready to fight for their freedom. I yield back my time.

Mr. COHEN. Thank you, Mr. Chair. Mr. Collins is at the end of the table. He is the ranking member of the committee, and he is now recognized for his opening statement.

Mr. COLLINS. Thank you, Mr. Chairman. I do appreciate that. The title of this hearing is "Threats to Reproductive Rights in America." The rights mentioned in the title refer to the Supreme Court's 1973 decision in *Roe v. Wade*. As members of the Judiciary Committee, it is appropriate to examine why the test of time has exposed *Roe* as a failure in the viable judicial precedent. As mothers, fathers, sisters, brothers, and friends, it is necessary to consider why *Roe* is a failure of compassion for both women and children.

While *Roe* asserts a woman's right to privacy, anchors her right to abortion, abortion destroys the right to life along with liberty, the pursuit of happiness, and all other constitutional rights of the children it kills. It is impossible to imagine the framers intending the right of privacy to eclipse one of the self-evident, unalienable rights that motivated the birth of our Nation.

Contending an unborn child has no life to lose becomes impossible when we reflect, even momentarily, on what an abortion entails, and I am grateful for our witnesses today who are here to look at the lives abortions would have snuffed out. These witnesses are not alone in recognizing the humanity of an unborn child. In her dissenting opinion in *Gonzales v. Carhart*, Justice Ginsburg argued that "Compared to a partial birth abortion, the common dismemberment abortion method could have equally been characterized as brutal, involving, as it does, tearing apart a fetus and ripping off his limbs."

Let us then be honest. Let us not speak of abortion as a victimless crime. At best, abortion is aimed at one person's suffering at the expense of another person's existence. We must cultivate compassion and practical support for women who find themselves pregnant under difficult or oppressive circumstances, and we must protect the most defenseless humans among us, those living in the womb. One person's reproductive right cannot outweigh another person's right to live.

Justice Ginsburg also took issue with *Roe* on legal grounds. As a law professor, she wrote "*Roe*, I believe, would have been more acceptable as a judicial decision if it had not gone beyond the ruling of the statute before the Court." Heavy-handed judicial intervention was difficult to justify. Other pro-choice legal experts have also voiced concerns with the foundation of this decision. Edward Lazarus, a former clerk to Justice Blackmun, who wrote the majority opinion in *Roe*, said, "As a matter of constitutional interpretation and judicial method, *Roe* borders on the indefensible. I say this as someone who is utterly committed to the right to choose. The problem is that *Roe* has little connection to the constitutional right it purportedly interpreted. A constitutional right to privacy broad enough to include abortion has no meaningful foundation in the

constitutional text, history, or precedent.” Mr. Lazarus went on to say, “As a matter of constitutional interpretation, even most liberals, even if you administer truth serum, will tell you it is basically indefensible.”

Jeffrey Rosen, formerly of the New Republic and currently the president of the National Constitution Center in Philadelphia, wrote, “Thirty years after Roe, the finest constitutional minds in the country still have not been able to produce a constitutional justification for striking down restrictions on early term abortions that are substantially more convincing than Justice Harry Blackmun’s famously artless opinion itself. As a result the pro-choice majority asks nominees to swear allegiance to the decision without being able to identify an intelligible principle to support it.” Kermit Roosevelt, a law professor at Penn Law School, said, “It is time to admit in public that, as an example of practice of constitutional opinion writing, Roe is a serious disappointment. As a constitutional argument, Roe is barely coherent. The Court pulled its fundamental right to choose more or less from the Constitution either.”

As a result of Roe’s lack of legal justification, the Supreme Court has since limited its effect. 1992’s *Planned Parenthood v. Casey* permitted States to regulate abortions in the first trimester or in any State before fetal viability, provided that they do not pose an undue burden on a woman’s right to abortion. In 2003, Congress banned partial birth abortions, which none other than Justice Ginsburg had called brutal. In a partial birth abortion, a living baby was delivered feet first, skull crushed before its chin clears the uterus, almost before live birth is complete.

2007, the Supreme Court upheld the Federal ban which applied at any point during pregnancy in *Gonzales v. Carhart*, ruling the Federal law did not impose an undue burden on a woman’s right to an abortion. Justice Kennedy’s majority opinion noted the law expresses respect for the dignity of human life and affirmed the government’s interest in protecting the medical profession’s integrity. He wrote, “The government may use its voice and its regulatory authority to show its profound respect for the life within the woman.” Mr. Chairman, the decade since *Roe v. Wade* has repeatedly delivered legal decisions making it clear any threat to *Roe v. Wade* is posed by illogical majority opinion.

Before I finish, however, I will have to take exception with my chairman of the full committee. To call the ranking member of this subcommittee arrogant for expressing his personal beliefs while at the same time sitting hypocritically stating your own beliefs from a belief that would assume comes from a moral or civic background is the height of hypocrisy. At this point in time, we can disagree, but at least if we are going to call it, call the balls and strikes the same way. With that, I yield back.

Mr. COHEN. Thank you, Mr. Collins. We welcome our witnesses and thank them for participating in today’s hearing. Please note that your written statement will be entered into the record in its entirety. Accordingly, I ask you to summarize your statement and your testimony in 5 minutes. You have a lighting system in front of you. The green light means you are going, the yellow light

means you have 1 minute left, and the red light means over. Stay within that limit. You have got those lights.

Before proceeding, I would remind each of you that all of your written and oral statements made to this subcommittee in connection with this hearing are subject to penalty of perjury pursuant to the U.S.C. 18-1001 that could result in the imposition of fine or imprisonment up to 5 years or both.

Our first witness is Ms. Melissa Murray. She is a professor of law and co-director of the Birnbaum Women's Leadership Network at New York University School of Law, where she teaches con law, family law, criminal law, reproductive rights, and justice, among other courses. Her publications appear or are forthcoming in the California Law Review, the Columbia Law Review, the Harvard Law Review, the Michigan Law Review, the Penn Law Review, and Yale Law Journal, and the Virginia Law Review. I don't see how you have time to teach all those courses.

She is an author of *Cases on Reproductive Rights and Justice*, the first case book to cover the field of reproductive rights and justice. And prior to joining the NYU faculty, she was on the faculty at the University of California-Berkeley School of Law and served as an interim dean there. Professor Murray received her J.D. from Yale. She is a noted development editor of the Yale Law Journal. After law school she clerked for the Honorable Sonia Sotomayor, then a judge on the U.S. Court of Appeals for the U.S. District Court for the District of Connecticut.

She received her undergraduate degree from the basketball powerhouse, University of Virginia, and she is recognized now for 5 minutes.

STATEMENTS OF MELISSA MURRAY, ESQUIRE, PROFESSOR OF LAW, NEW YORK UNIVERSITY SCHOOL OF LAW, NEW YORK, NEW YORK; BUSY PHILIPPS, ACTOR AND ADVOCATE, OAK PARK, ILLINOIS; OWEN PHILLIPS, M.D., F.A.C.O.G., THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER, MEMPHIS, TENNESSEE; CHRISTINA BENNETT, COMMUNICATIONS DIRECTOR, FAMILY INSTITUTE OF CONNECTICUT, HARTFORD, CONNECTICUT; MELISSA OHDEN, KANSAS CITY, MISSOURI; JENNIFER DALVEN, DIRECTOR, ACLU REPRODUCTIVE FREEDOM PROJECT, NEW YORK, NEW YORK; YASHICA ROBINSON, M.D., MEDICAL DIRECTOR, ALABAMA WOMEN'S CENTER FOR REPRODUCTIVE ALTERNATIVES, HUNTSVILLE, ALABAMA; AND H.K. GRAY, ACTIVIST, YOUTH TESTIFY, DALLAS-FORT WORTH, TEXAS

STATEMENT OF MELISSA MURRAY

Ms. MURRAY. Thank you very much for the opportunity to appear before you in these hearings on threats to reproductive rights in United States. I am Melissa Murray, a professor of law at New York University School of Law. I will not recount my credentials as Mr. Cohen is the best PR man that I could have on this subject. [Laughter.]

So let me get right to it. In 1973 in *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 United States Supreme Court has consistently affirmed a woman's right to choose an 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 abortion 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.

And indeed, as recently as 2016, the Court in *Whole Women's Health v. Hellerstedt* reiterated this commitment to upholding abortion rights. There, the Court struck down two Texas laws and specifically noted that the undue burden standard was not a permissive endorsement of the State's purported rationales for regulating abortion. Instead, reviewing courts are obliged to review the State's purported justifications and determine independently if the challenged restrictions are appropriate measures to achieve the desired legislative ends.

Still, despite these longstanding 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. They purport to promote and protect women's health, but, in fact, these laws are part of a larger effort to legislate abortion out of existence through piecemeal attacks.

Recent changes in the composition of the U.S. Supreme Court and the lower Federal courts have further emboldened those seeking to limit a woman's right to choose an 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. They are no longer content to chip away at the abortion right through piecemeal legislation, and instead these more recent laws are an obvious provocation designed to relitigate and ultimately to overturn *Roe v. Wade*.

The prospect of overturning *Roe v. Wade* is the most obvious threat to reproductive rights, but it is not the only threat, nor is it even the most immediate threat. Even if *Roe v. Wade* is not overturned, there are a number of cases currently pending in the pipeline to the Supreme Court that concern access to abortion. The law challenges in these cases do not challenge *Roe* directly, but rather seek to strangle access to abortion, putting this fundamental right out of reach. They are part of this well-worn strategy to dismantle abortion rights through a death by a thousand cuts.

If these laws are upheld, whether by the Supreme Court or the lower Federal courts, their impact will be profound, particularly for our most underserved communities. These communities include individuals struggling to make ends meet, women of color, particularly African-American, Latinx, Asian-American and Pacific Islander and native women, rural women, immigrant women, individuals in the LGBTQ community, parents who already have children, and young people. These constituencies already face enormous barriers to obtaining reproductive care, basic healthcare, and economic security. Threats to abortion access further exacerbate these pressures.

Barriers to healthcare, including reproductive care, go hand-in-hand with economic insecurity. The affordable housing crisis, food insecurity, a lack of clean water, the lack of affordable childcare, the wage gap, which is more pronounced 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 this country. These barriers have only increased under this presidential Administration.

For all of these reasons, I urge this subcommittee to keep these urgent threats and these underserved constituencies in mind as you consider ways to support and protect the constitutional right to abortion. Thank you.

[The statement of Ms. Murray follows:]

TESTIMONY OF MELISSA MURRAY
PROFESSOR OF LAW, NEW YORK UNIVERSITY SCHOOL OF LAW

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

HEARING ON THREATS TO REPRODUCTIVE RIGHTS IN
AMERICA
JUNE 4, 2019

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 *Carry 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 *Jane 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*.³³⁴ 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*.³³⁵

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.

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 Sc. 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 Gerds 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. Marcella 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://latainstitute.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&pctype=Homepage> (discussing research from the Advancing New Standards in Reproductive Health project at the University of California, San Francisco).

Mr. COHEN. Thank you, Professor. Our next witness is Ms. Busy Philipps. She is a best-selling author, an actress, a writer, and a host of a late-night talk show. She has appeared in a number of movies and television shows. Last month she revealed in her talk show that she had had an abortion when she was a teenager. She has been a vocal advocate for abortion rights, a brave lady, and we recognize her for 5 minutes.

STATEMENT OF BUSY PHILIPPS

Ms. PHILIPPS. Chairman Cohen, Ranking Member Johnson, members of the subcommittee, thank you for having this important conversation and for inviting me to be a part of it. My name is Busy Philipps. I am many things. I am a mother of two wonderful girls, age 10 and 5. I am a professional actor for over 20 years. I am a New York Times best-selling author. I am a wife. I am a daughter. I am a talk show host and a volunteer for various children's charities and my kids' schools. I am a sister, and I am a best friend. I am also the 1 in 4 women in this country who have an abortion.

After the governor of Georgia signed Bill H.B. 481, which would ban abortion at 6 weeks, before most women know they are pregnant, I felt compelled to share my own story on my televisions and online. I had an abortion when I was 15 years old in my home State of Arizona in 1994. It was not a decision that I made lightly, but I have never for one moment doubted that it was the right decision for me. But so much has changed in Arizona and many other States since then. If I were that same 15-year-old in Arizona today, legally I would have to get parental consent. I would be forced to undergo a medically unnecessary ultrasound, go to a State-mandated in-person counseling session designed solely to shame me into changing my mind, and then take a State-mandated 24-hour timeout to make sure I really know what I wanted. And finally, I would be forced to give the State a reason why. Well, here is mine. It is my body, not the State's.

Women and their doctors are the ones that are in the best position to make informed decisions about what is best for them, no one else. Since I shared my story and I called on others to do so using the hashtag, #YouKnowMe, on social media, the response have been overwhelming. I have heard from thousands with their own stories, women who were raped, people who very much wanted children and had severe, severe fetal anomalies, women who were in an abusive relationship, people whose birth control failed or who simply were not ready. I also heard from many women who had abortions before abortion was legal in 1973, putting themselves in dangerous circumstances.

No bill that criminalizes abortion will stop from making this incredibly painful decision. These bans will not stop abortions from happening, but they will drive women and girls and people into the shadows, which is what this has always been about, shaming and controlling women's bodies. In the week after I shared my story on my show, women were coming up to me in the street, in the supermarket, at my gym, with tears in their eyes thanking me for my bravery. But the word "brave" didn't sit right with me. Why is it brave to speak to an experience that millions of people around the

world throughout history have gone through? And then I realized it is considered brave because as women, we have been taught to feel shame about our bodies since birth. In my life, I have had many medical procedures, but no one has ever called me brave for talking about them. Abortion is healthcare and should not be treated as different from any other healthcare.

I am so sad that we have to sit here in front of a row of politicians and give deeply personal statements because the why doesn't matter. It should not matter. I am a human being that deserves autonomy in this country that calls itself free, and choices that a human being makes about their own bodies should not be legislated by strangers who can't possibly know or understand each individual's circumstances or beliefs. I am here today because I stand by the decision that I made when I was 15 years old. I am here today because my platform has allowed me to connect with thousands and thousands of people around the country that you represent, who have made the same choice I have made, but who will not all get the same chance to talk to you directly.

I am here today to help de-stigmatize a legitimate medical procedure and continue to encourage women not to allow themselves to be shamed for their choices. And finally, I am here today for my two little girls, Birdie and Cricket. My dream for them is that they will live in a world in which women are truly equal with complete control over their own reproductive health. That is the dream I hold for all people, regardless of their privilege or parents or what State they live in.

That dream is slipping further and further from reality with every ban passed. I hope that you, our elected leaders, can help us reverse the tide. Thank you. I look forward to today's discussion.

[The statement of Ms. Philipps follows:]

Chairman Cohen, Ranking Member Johnson, members of the subcommittee, thank you for having this important conversation, and for inviting me to be part of it.

My name is Busy Philipps.

I am many things. I am a mother to two wonderful girls, 10 and 5, I am a professional actor for over twenty years and a *New York Times* best selling author. I am a wife and a daughter and a talk show host and a volunteer for various children's charities and my kid's schools. I am a sister and I am a best friend.

I am also the one in four women in this country who have had an abortion. After the Governor of Georgia signed bill HB 481, which would ban abortion at six weeks, before most women know they're pregnant, I felt compelled to share my own story on my late night tv show and online.

I had my abortion when I was 15 years old, in my home state of Arizona in 1994. It was not a decision I made lightly. But I have never for a moment doubted that it was the right decision for me.

But so much has changed — in Arizona and other states — since then.

If I were that 15 year old girl in Arizona today, legally I would have to get parental consent. I would be forced to undergo a medically unnecessary ultrasound, to go to a state-mandated in-person counseling, designed solely to shame me into changing my mind, then take a state-mandated 24-hour time out to make sure I really knew what I wanted. And finally, I would be forced to give the state a reason WHY.

Well, here is mine: my body belongs to me, not the state. Women and their doctors are in the best position to make informed decisions about what is best for them. No one else.

Since I shared my story and called on others to do the same using the hashtag #YouKnowMe on social media, the response has been overwhelming.

I have heard from hundreds of thousands with their own stories: women who were raped, women whose very wanted children had severe fetal anomalies, women who were in abusive relationships, women whose birth control failed or who simply weren't ready. I also heard from women who had abortions before abortion was legal in 1973, putting themselves in dangerous circumstances.

No bill that criminalizes abortion will stop anyone from making this incredibly personal decision. These bans will not stop abortion from happening. But they will drive women and girls into the shadows. Which is what this has always been about. Shaming and controlling women's bodies.

In the week after I shared my story on my show, women were coming up to me on the street, in the supermarket and at the gym with tears in their eyes, thanking me for my bravery. But the word bravery didn't sit right with me. Why is it brave to speak to an experience millions of people in the world throughout history have gone through? And then I realized. It is considered brave because as women we have been taught to feel shame about our bodies from birth.

In my life I have had many medical procedures. But no one has ever called me "brave" for talking about them. Abortion is health care, and should not be treated as different from any other health care.

I am sad that we have to come before a row of politicians and give these deeply personal statements. Because the WHY doesn't matter, it should not matter. I am a human being that deserves autonomy in this country that calls itself free. And choices that a human being makes about their own bodies should not be legislated by strangers who can't possibly know or understand each individual's circumstances or beliefs.

I am here today because I stand by the decision I made when I was 15. I am here today because my platform has allowed me to connect with thousands and thousands of people around the country who have made the same choice I made, but who will not all get the chance to come speak to you directly. I am here today to help destigmatize a legitimate medical procedure and continue to encourage women to not allow themselves to be shamed for their choices.

And finally, I am here today for my two little girls, Birdie and Cricket . My dream for them is that they will live in a world in which women are truly equal, with complete control over their own reproductive health. That is the dream I have for all women, regardless of their privilege or parents or what state they live in.

That dream is slipping further and further from reality, with every ban passed.

I hope that you, our elected leaders, can help us reverse the tide.

Thank you, and I look forward to today's discussion.

Mr. COHEN. Thank you very much. Our next witness is Dr. Owen Phillips, a friend from Memphis, Tennessee, who has come to visit me on many occasions about these issues and others. She is a professor at the University of Tennessee Health Science Center in Memphis. She has held that position since 2002. She is a fellow in the American College of Obstetricians and Gynecologists and Board certified by the American Board of Obstetrics and Gynecology and the American Board for Medical Genetics.

She received her M.D. from the University of Mississippi School of Medicine in 1980. She did her residency in obstetrics and gynecology at the University of Mississippi Medical School, and her fellowship in reproductive genetics at the University of Tennessee in Memphis. She has also received a master's in public health degree, summa cum laude from the University of Memphis. She received her B.S. in chemistry from Millsaps.

Welcome. You are recognized for 5 minutes.

STATEMENT OF OWEN PHILLIPS, M.D., F.A.C.O.G.

Dr. PHILLIPS. Thank you, Chairman Cohen. Chairman Nadler, Ranking Member Johnson, and members of the committee, thank you again for inviting me to speak with this subcommittee today. My name is Owen Phillips. I am an obstetrician/gynecologist from Memphis, Tennessee. I was asked to testify as to the barriers to care my patients experience because of existing restrictive abortion laws, and to predict what further challenges might arise if even more restrictive abortion regulations become law.

The first I can easily attest to. Tennessee has several laws that were passed under the guise of making abortion safer. None were backed by scientific evidence and all have fulfilled their real purpose: making a safe and legal procedure harder to obtain. The 48-hour wait period requires many women to travel long distances twice to the clinics for face-to-face consenting, adversely affecting their job and childcare. The requirement that physicians provide abortion care have hospital privileges has prevented many experienced doctors from caring for their patients.

My own hospital has bowed to perceived political pressure and severely limits the indication for abortions. None of these restrictions will likely prevent women from attaining the abortion they seek. They just make it harder for women to receive timely, efficient, and equitable abortion services.

To answer the second question, what effects would more restrictive laws have, is harder to answer. I have been practicing since the 1980s. I am not old enough to have personally witnessed the tragedies my physician teacher recalled prior to the Roe decision. No one knows what the consequences will be because almost all doctors practicing now have assumed that safe and legal abortion would always be an option for their patients.

Nevertheless, we physicians are fearful. Commonly a diagnosis of preeclampsia is made in our unit. By definition, this diagnosis is made after 20 weeks. This is a life-threatening condition for which the treatment is delivery. Abortion is often recommended, and the timing of which is made by the doctor with the patient. No politician's opinion should be a part of that medical and personal decision making, but this is where we seem to be headed. And I agree

with the vice president of health policy at ACOG, who has opined that one contributing factor to the increasing rates of maternal mortality has been the favoring of fetal wellbeing over that of the patient.

Also typical of my experience is having the heartbreakng conversation with a couple that their pregnancy has a lethal condition, meaning the baby will die within the first few hours or days of life. The couple, after much anguish, may decide to have an abortion or may not, but who among us feels they have the right to make that decision for them? Not me, but I assume people sitting in some State legislatures or maybe even some of you feel that you do.

And it is not just OBGYNs who interface with the issue. The oncologist's decision to treat with cancer-curing drugs is affected by a woman's pregnancy. The cardiologists have to advise women that if they continue their pregnancy, they may or will die from their condition. It is a hard decision, but the woman may look at the young children she has and ask what is the right thing for them. I would never deem myself so arrogant to make this decision for a woman, yet politicians all over this country have decided that they have the right to do just that.

Is this a religious cause? You know, I understand religious conviction. I was raised a Southern Baptist. Was taught to live by the Bible's teaching, "love your neighbor as yourself" and "judge not lest ye be judged." But these laws are not about love and certainly not about refraining from judging others. Where is the ethical and moral high ground in risking a woman's life or wellbeing because she cannot make decisions about her own body, her family, and her wellbeing, whether or not to have a baby, or safely terminate her pregnancy?

Now, most of my patients may have medical conditions for pregnancy termination, but in my experience, every woman who makes this decision has a reason. Abortion is a part of healthcare and should remain safe, accessible, and legal without political interference. I agree with ACOG's recommendation that existing restrictive abortion laws should "be immediately repealed." These laws do not seek to make abortion safer. They instead seek to punish the healthcare systems and doctors who provide abortion care, and, above all, to punish the women who seek abortion services.

The decision to have an abortion should be a woman's decision in consultation with her doctor, period. Thank you.

[The statement of Dr. Phillips follows:]

June 4, 2019

Testimony from Dr. Owen Phillips to the Subcommittee on the Constitution, Civil Rights and Civil Liberties on Threats to Reproductive Rights in America

Thank you, Chairman Cohen and Ranking member Collins for inviting me to speak with the subcommittee today.

I am an obstetrician-gynecologist in Memphis Tennessee. I was asked to testify as to the barriers to care my patients experience because of existing restrictive abortion laws and to predict what further challenges might arise if even more restrictive abortion regulations become law.

The first, I can easily attest to. Tennessee has several laws that were passed under the guise of making abortion safer. None were backed by scientific evidence and all have fulfilled their real purpose- making a legal and safe procedure harder to obtain. The 48-hour wait period requires many women to travel long distances twice to the clinics for face to face consenting, adversely affecting their job and child care. The requirement that physicians providing abortion care have hospital privileges has prevented many experienced doctors from caring for patients. My own hospital has bowed to perceived political pressure and severely limits the indications for abortions. None of these restrictions will likely prevent women from obtaining the abortion they seek. They just make it harder for women to receive timely, efficient, and equitable abortion services.

To answer the second question, what affects would more restrictive laws have, is harder to answer.

I have been practicing since the 1980's. I am not old enough to have personally witnessed the tragedies that my physician teachers recalled prior to the Roe decision. No one knows what the consequences will be, because almost all doctors practicing now have assumed that safe and legal abortion would be an option for their patients.

Nevertheless, we physicians are fearful. Commonly, a diagnosis of preeclampsia is made in our unit; by definition this diagnosis is made after 20 weeks. This is a life-threatening condition for which the treatment is delivery. Abortion is often recommended and the timing of which is made by the doctor with the patient. No politician's opinion should be a part of the medical and personal decision-making. But this is where we seem to be headed. And, I agree with Dr. Barbara Levy, vice president of health policy at the American College of Obstetricians and Gynecologists who opined that one contributing factor to the increasing rates of maternal mortality has been the favoring of fetal well-being over that of the mother. Also, typical of my experience is having the heart-breaking conversation with a couple that their pregnancy has a lethal condition, meaning the baby will die within the first few hours or days of life. The couple, after much anguish, may decide to have an abortion. Or may not. But who among us feels they have the right to make that decision for them. Not me. But I assume people sitting in some state legislatures or maybe even some of you feel you do.

And, it is not just Ob-Gyns who interface with the issue. The oncologist's decision to treat with cancer-curing drugs is affected by a woman's pregnancy. The cardiologists have to advise women that if they continue their pregnancy, they may or will die from their condition. It is a hard decision. But that woman may look at the young children she has and ask what is the right thing for them, as any mother would. I would never deem myself so arrogant to make this decision for a woman. Yet, politicians all over this country have decided that they have the right to do just that.

Is this a religious cause? You know, I understand religious conviction. I was raised a Southern Baptist. I was taught to live by the Bible's teachings: love your neighbor as yourself and judge not lest ye be judged. But these laws are not about love and certainly not about refraining from judging others. Where is the moral high ground in risking a woman's life or well-being because she cannot make decisions about her own body, family and well-being, whether or not to have a baby or safely terminate her pregnancy?

Most of my patients may have medical indications for pregnancy termination, but in my experience every woman who makes this decision has a reason. Abortion is a part of healthcare and should remain safe, accessible and legal and without political interference. I agree with the American College of Obstetricians and Gynecologists recommendation that existing restrictive abortion laws "should be immediately repealed." These laws do not seek to make abortion safer. They instead seek to punish the health care systems and doctors who provide abortion care and above all to punish the women who seek abortion services. The decision to have an abortion should be the woman's decision in consultation with her doctor period.

Thank you.

Mr. COHEN. Thank you very much, Dr. Phillips. Our next witness is Christina Bennett. She is the communications director of the Family Institute of Connecticut. She has been active in the pro-life movement for 15 years. She is a licensed Christian minister and has served on prayer missions in a number of locations, including Washington, Atlanta, and several overseas countries. She has a B.S. in communications from Southern Connecticut State University.

Ms. Bennett, you are recognized for 5 minutes.

STATEMENT OF CHRISTINA BENNETT

Ms. BENNETT. Thank you, Chairman Nadler, Chairman Cohen, Ranking Member Johnson, and members of the committee. I am grateful for the opportunity to share my story with you today.

In 1981, my mother scheduled to abort me at Mount Sinai Hospital in Hartford, Connecticut. She was pressured by my father to abort and rejected by a mentor in her church who told her she wasn't welcome anymore because she was pregnant out of wedlock. She met with a counselor at the hospital who assured her she was making the right decision, but didn't offer counseling on available alternatives. A black elderly janitor approached my mother after seeing her crying in the hospital hallway. She asked her if she wanted to have her baby. My mother said yes. She told her that God would give her the strength to have me.

When she went to leave, my mother was called into the doctor's office, and she saw that he hadn't cleaned up the blood from the last abortion. She was disgusted and told him she wanted to keep me. He insisted that she go through with the abortion and said, "You have already paid for this. You are just nervous." She repeated, "I want my baby," and he yelled at her saying, "Do not leave this room." She felt his anger came from fear of losing her business and those that could possibly follow her, yet with courage she walked out.

Children conceived less than a decade prior to my birth never experienced the threat of death through legalized abortion. It is easy for people to say, "Well, I am glad your mother had a choice," but a statement like that devalues my existence and the reality of what that choice would have done to me. Human life should not be weighed in the balance of whether or not they are wanted or measured in terms of circumstances or convenience. I deserved legal protection and a right to life.

My mother's experience is similar to the experiences I have heard from women throughout this country, women who faced the same rejection, pressure, lack of counseling, lack of support, and disgusting facility conditions. My desire to assist women and children led me to work for years at a nonprofit pregnancy resource center, and there I witnessed the power of hope and the ways in which love and practical support can strengthen women and their families.

Two years ago I had a profound experience while visiting the National Museum of African-American History. I was reminded of the ways black Americans were denied the right to equal protection and due process, treated as property, and dehumanized because of the color of our skin. The museum memorialized the many ways

black Americans have been unjustly targeted and killed for centuries. And while I rejoice over the progress that we have made as people of color, an ache remains in my heart because of the denial of equal protection and due process to another class of people: the baby in the womb.

The sacrifices my ancestors suffered to achieve the civil rights I enjoy today are not able to protect future generations because of legalized abortion. I am burdened that the Fourteenth Amendment, which gave us liberty, was unjustly used to invent a supposed right to destroy a human life. Sojourner Truth in her day said, "Am I not a woman?," and in mine I say, "Am I not a person?" Abortion is not a victimless act. We just can't hear the voices of those who have been silenced and discarded.

Roe v. Wade rendered 60 million lives unworthy of legal protection and had led to the deaths of 20 million black babies since 1973. In the dark history of Planned Parenthood, founder Margaret Sanger's philosophy of eugenics was recently documented by Supreme Court Justice Thomas in his concurring opinion about *Fox v. Planned Parenthood*. And today, an increasing number of black Americans recognize this eugenic population control philosophy that is having a genocidal impact.

Seventy-eight percent of Planned Parenthood surgical facilities are located in black and Latino neighborhoods, and black women, such as Cree Erwin, Lakisha Wilson, and Tonya Reaves, have lost their lives at the hand of an abortion industry that offered them substandard medical care. Others have left by ambulance, suffered botched procedures, and been left with physical and emotional scars. And we are tired of the targeting and the lies that abortion is an answer to our challenges.

As a pro-life feminist, I support body autonomy, but abortion impacts two bodies. I am a unique individual, and just as my heart is beating today, it was beating inside of my mother's body. I was not just a part of her body. And liberation never comes through oppressing other human beings. *Roe v. Wade* was built on lies that Norma McCorvey spent her entire life trying to correct. We can love both women and children and strive for a society that treats us all with the dignity we deserve, and this is true empowerment.

[The statement of Ms. Bennett follows:]

Christina Bennett
Director of Communications
Family Institute of Connecticut
June 4, 2019
Threats to Reproductive Rights in America

Dear Chairman Nadler, Chairman Cohen, Ranking Member Johnson and members of the committee:

My name is Christina Bennett and I'm submitting this testimony in hopes that my personal story will shed light on the issue of abortion in America. In 1981 my mother scheduled to abort me at Mount Sinai Hospital in Hartford, CT. She was pressured by my father to abort and rejected by a mentor in her church who told her she wasn't welcome anymore because she was pregnant out of wedlock. She met with a counselor at the hospital who only assured her she was making the right decision and did not offer counsel on available alternatives.

A black elderly janitor approached my mother after seeing her crying in the hospital hallway. She asked her if she wanted to have her baby and when she said yes, she told her God would give her the strength to have me. When she went to leave my mother was called into the doctor's office where she could see he hadn't cleaned up the blood from the last abortion which disgusted her. He insisted she stay and when she said she wanted to keep me he said, "You've already paid for this. You're just nervous." She repeated her desire to keep me and he yelled at her screaming "Don't leave this room", but she walked out. My mother's experience in that hospital is being repeated every day that abortion is performed in this nation. Women are facing the same coercion, the same shunning, the same lack of counseling and disgusting facility conditions. Unfortunately, many women lack a compassionate advocate to offer them the support and resources they need. This is why I spent four years working at a non-profit pregnancy resource center, practically serving hundreds of women and their children.

Two years ago, I had a profound experience while visiting the National Museum of African-American History. I was reminded of the ways Black Americans were denied the right to equal

protection and due process, treated as property and dehumanized because of the color of our skin. The museum memorialized the many ways Black Americans have been unjustly targeted and killed for centuries. While they showcased examples of the progress Black Americans have made, an ache remains in my heart because of the denial of equal protection and due process to another class of people – the baby in the womb. The sacrifices my ancestors suffered to achieve the freedom and civil rights I enjoy today are not able to protect future generations from a decision made just 8 years before my birth. The Roe v Wade decision rendered 60,000,000 lives unworthy of legal protection and has led to the deaths of over 20 million Black babies since 1973.¹

Babies conceived just a decade prior did not experience the threat of death through legalized abortion. Their lives were not weighed in the balance of whether or not they were wanted. The value of their lives was not measured in terms of their parents' challenging circumstances or convenience.

The dark history of Planned Parenthood founder Margaret Sanger's philosophy on Eugenics and population control was documented by Supreme Court Justice Clarence Thomas' concurring opinion in *Box v. Planned Parenthood* in Indiana and Kentucky. Today, an increasing number of Black Americans recognize this eugenic and population control philosophy that is having a genocidal impact.

Recently close to a hundred black women of influence - gathered in Charlotte, NC to protest the stealth opening of a Planned Parenthood in the city's oldest Black neighborhood. Along with my testimony I've attached a statement from Lesley Monet, International Director of The Church of God in Christ's Family Life Campaign. Lesley explains the largest Black denomination with

¹ Centers for Disease Control and Prevention, Abortion Surveillance- United States, 2011, available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6311a1.htm?s_cid=ss6311a1_w

over 6 million members' opposition to the abortion industry's targeting of Black babies and the Church's program to protest abortion and encourage adoption.

Many of us are tired of the targeting. 78% of Planned Parenthood's surgical facilities are located in Black and Latino neighborhoods.² Black women such as Cree Erwin, Lakisha Wilson, and Tonya Reaves have lost their lives at the hands of an abortion industry that offers substandard medical care as increasingly women are leaving abortion centers by ambulance.³

Taking the lives of our children through abortion doesn't empower or strengthen our communities. Abortion has left behind countless wounded women and men as it silenced millions of children who otherwise would have had a voice and lived out the purpose for their life.

² https://www.protectingblacklife.org/pp_targets/index.html

³ <https://www.sba-list.org/negligence>

Mr. COHEN. Thank you, Ms. Bennett.

Ms. BENNETT. You are welcome.

Mr. COHEN. Ms. Melissa Ohden is an anti-abortion activist. In 2012, she founded the Abortion Survivors Network and has previously testified before the U.S. House of Representatives and the U.S. Senate. She has worked as a speaker for Feminists for Life. You are recognized for 5 minutes.

STATEMENT OF MELISSA OHDEN

Ms. OHDEN. Chairman Cohen, Chairman Nadler, Ranking Member Johnson, members of the committee, I just want to thank you for inviting me to this hearing.

As a now famous saying goes, "Women's rights are human rights." I am here today to give a face and a voice to women whose rights are not just being threatened, but have been under attack for the past 46 years in our country, and are clearly being even more heavily threatened as abortions throughout all 9 months of pregnancy with no restriction are being introduced and celebrated in States like New York, Illinois, and now Nevada.

Today you have heard countless stories already about how abortion is a difficult, yet necessary, decision, how every woman has the fundamental right to abortion. Every story is important. Every experience deserves to be heard. However, when we hear the stories about abortion, this narrative is woefully one-sided. Our culture has been inundated with messaging in which abortion controls the narrative, yet largely ignored in this abortion narrative that is woven so skillfully throughout our culture, behind even the words in the title of this hearing, "Reproductive Rights," are stories buried beneath the narrative of abortion that has been sewn since *Roe v. Wade*.

Is there space for stories like mine, women who are alive today after surviving failed abortion procedures? For stories like my biological mother's, who have been coerced or forced into an abortion? Do we ever create space for the stories of women who regret their abortions? The most important stories, though, are those that you will likely never hear, the stories of the little girls who will never live outside of the womb. In all of this discussion about women's rights, some lose sight of the fact that without the right to life, there are no other rights. This is the greatest human rights issue we are facing as a country.

And I am here to tell you that in August of 1977, that is when the attack on my human rights began. My biological mother as a 19-year-old college student had a saline infusion abortion forced upon her by her own mother, a prominent nurse in their community, with the help of her friend and colleague, the local abortionist, Dr. Kelberg. That abortion procedure involved injecting a toxic salt solution into the amniotic fluid surrounding me in the womb. It was meant to poison and scald me to death. I soaked in that toxic salt solution over a 5-day period as they tried time and time again to induce my birth mother's labor with me.

When I was finally expelled from the womb on that 5th day of the abortion procedure, my arrival into this world was not so much as a birth, but an accident, a live birth after a saline infusion abortion. My medical records actually state a saline infusion for an

abortion was done, but was unsuccessful. This record is available to you to review along with some other records that talk about how a complication of my birth mother's pregnancy was a saline infusion.

Despite the arguments being made that people like me don't exist or that children aren't left to die after failed abortions, I need you to listen to the words of a nurse who have been connected with who was there that day. I was initially laid aside after my grandmother instructed the nurses to leave me to die, and arguments ensued about whether would be provided medical care. In the words of Nurse Jan, who received me in the NICU that day, a tall, blonde nurse courageously rushed me off, shouting out, "She just kept gasping for breath. And so I couldn't just leave her there to die."

My medical records state that when I was delivered alive in that abortion procedure, I suffered from severe respiratory problems, jaundice, seizures. I weighed a little less than 3 pounds. I was 2 pounds, 14 ounces, which led a neonatologist to remark in my records that I was approximately 31 weeks gestation as opposed to the 18 to 20 weeks that the abortionist had written on my medical records. It is easy to talk about women's reproductive rights until you recognize that without first the right to life, there are no other rights. How do you reconcile my rights as a woman, who survived a failed abortion, with what is being discussed here today?

The abortion industry talks in abstract and gray when it comes to the science of when life begins and what abortion does, but the reality is much clearer. I am alive today because someone else's reproductive right failed to end my life, as are the 287 abortion survivors I have connected with through my work in the Abortion Survivors Network. One hundred and eighty-four of them are female. There is something wrong when someone's right results in another person's death. There is something deeply disturbing about the reality in our world that I have a right to an abortion, but I had never the simple right to live.

As you examine the so-called threat to women's reproductive rights, I would ask you to look behind the language and see stories like mine that are hidden, that might seem inconvenient or rare, and consider there is more to this discussion. And there is more to be done to protect our most vulnerable constituents and meet the needs of women and families in our communities in a way that supports life at all stages of development and in all circumstances, not ends it.

[The statement of Ms. Ohden follows:]

Melissa Ohden
MSW, Founder & Director, The Abortion Survivors Network
[REDACTED]

June 4, 2019

House Judiciary, Subcommittee on the Constitution, Civil Rights and Civil Liberties
Chairman, Representative Steve Cohen

Representative Cohen and Members of the Subcommittee, thank you for inviting me to this hearing titled "Threats to Reproductive Rights in America."

As the now-famous saying goes, "women's rights are human rights."

I'm here today to give a face and a voice to women whose rights are not just being threatened, but have been under attack for the past forty-six years in our country. And, are clearly being even more heavily threatened as abortion throughout all nine months of pregnancy, with no restriction, are being introduced and celebrated in states like New York, Illinois and now, Nevada.

Today, you will hear countless stories, I suspect, about how abortion is a difficult, yet necessary decision; how every woman has the fundamental right to abortion.

Every story is important. Every experience deserves to be heard.

However, when we hear stories about abortion, the narrative is woefully one-sided. Our culture has been inundated with messaging in which abortion controls the narrative.

Yet, largely ignored in the abortion narrative that is woven so skillfully throughout our culture, behind even the words in the title of this hearing, "reproductive rights," are stories buried beneath the narrative of abortion that has been sewn since Roe v. Wade.

Is there space for stories like mine, women who are alive today after surviving failed abortion procedures; for stories like my biological mother's, women who have been coerced or forced into an abortion? Do we ever create space for the stories of women who regret their abortions?

The most important stories, though, are likely the ones that you'll never hear. The stories of the little girls who will never live outside of the womb. In all of the discussion about women's rights, some lose sight of the fact that without the right to life, there are no other rights. This is the greatest human rights issue we are facing as a country.

In August of 1977, the attack on my human rights began. My biological mother, as a nineteen-year-old college student, had a saline infusion abortion forced upon her by her mother, a prominent nurse in their community, with the help of her colleague, the local abortionist, Dr. Kelberg.

This abortion procedure involved injecting a toxic salt solution into the amniotic fluid, that was meant to poison and scald me to death. I soaked in that toxic solution over a five day period as they tried time and time again to induce my birthmother's labor with me.

When I was finally expelled from the womb on that fifth day of the abortion procedure, my arrival into this world was not so much as a birth, but an accident, a "live birth" after a saline infusion abortion. My medical records actually state, "a saline infusion for an abortion was done, but was unsuccessful." I've included this record for you to review, along with another that identifies a complication of my birthmother's pregnancy as a saline infusion.

Despite the arguments being made that people like me don't exist or that children aren't left to die after failed abortions, listen to the words of a nurse who I've been connected with who was there that day. I was initially "laid aside," after my grandmother instructed nurses to leave me to die, and arguments about whether I would be provided medical care, ensued.

In the words of Nurse Jan, who received me in the NICU that day, "a tall blond nurse," courageously rushed me off to the NICU, shouting out, "she just kept gasping for breath, and so I couldn't just leave her there to die!"

My medical records state that the doctors initially suspected I had a fatal heart defect due to the high level of distress I presented with. I suffered from severe respiratory problems, jaundice, and seizures. I weighed in at 2 pounds, 14 ounces, which is what led a neonatologist to remark in my medical records that I was approximately 31 weeks gestation, as opposed to the 18-20 weeks that the abortionist had indicated.

It's easy to talk about women's reproductive rights until you recognize that without first the right to life, there are no other rights. How do you reconcile my rights as a woman who survived a failed abortion with what's being discussed here today?

The abortion industry talks in abstract and gray when it comes to the science of when life begins and what abortion does, but the reality is much clearer.

I'm alive today because someone else's "reproductive right" failed to end my life, as are the 287 abortion survivors I've connected with through my work with The Abortion Survivors Network, 184 of whom are female.

There's something wrong when one person's right results in another person's death. There's something deeply disturbing about the reality in our world that I have a right to an abortion but I never had the simple right to live.

The 14th Amendment says that "nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." But with states passing laws that state a "fertilized egg, embryo or fetus does not have independent rights," aren't states participating in the deprivation of life? Are states providing equal protection to all children? I don't think so. Each of you as a legislator has sworn to provide equal protection to your constituents under the law.

As you examine the so-called "threat to women's reproductive rights," I would ask for you to look behind the language and see the stories that are so often hidden, the stories that may seem inconvenient or even rare to you, and consider that there's more to this discussion.

And there's more to be done to protect your most vulnerable constituents and meet the needs of women and families in our communities in a way that supports lives at all stages of development and in all circumstances, not ends it.

Mr. COHEN. Thank you. Ms. Jennifer Dalven is the director of the American Civil Liberties Union Reproductive Freedom Project. In that role, she oversees and directs the ACLU's litigation, State advocacy, and communications work on issues affecting access to reproductive health services. Prior to that she was on the staff with the ACLU for more than 10 years and then in private practice. She graduated magna cum laude from the NYU School of Law and served as law clerk for the Honorable Pierre Leval of the U.S. Court of Appeals for the Second Circuit.

You are recognized for 5 minutes.

STATEMENT OF JENNIFER DALVEN

Ms. DALVEN. Chairman Cohen, Chairman Nadler, Ranking Member Johnson, and members of the subcommittee, thank you for inviting me to testify today. My name is Jennifer Dalven, and I am the director of the ACLU's Reproductive Freedom Project.

I have been litigating abortion cases for more than 2 decades, and I am here to tell you that today we are facing a crisis. Since March, seven States have passed laws banning abortion, and make no mistake about it. This has happened because President Trump was able to put two new justices on the Supreme Court, and abortion opponents believe that this new Court will take an extraordinary step of actually taking away one of our constitutional rights.

That is a very real and very frightening possibility, but here is the thing. The Court doesn't have to overturn *Roe v. Wade* in order for States to push abortion entirely out of reach. That is because these bans are just the culmination of a decades-long strategy, a strategy to pile restriction on top of restriction in order to make it near impossible for a person to get an abortion if they need one.

Congress started by passing the Hyde Amendment, which bans coverage for people insured through Medicaid. Representative Hyde openly admitted what his goal was, that it was to prevent people with low incomes from being able to get abortion care they needed. State legislatures followed suit, and since the 2010 elections, States have quietly passed 479 medically unnecessary restrictions on abortion care.

Lawyers at the ACLU, Planned Parenthood, and the Center for Reproductive Rights are challenging dozens of these restrictions in court. And while litigation is a powerful tool, it alone cannot stop the avalanche of restrictions. The unfortunate truth is that these restrictions have severely eroded access to care, so much so that for many today in our country, abortion is already more theoretical than real. This is particularly true for people with low incomes, people of color, immigrants, young people, and LGBTQ people.

Kentucky is a good example of what is happening around the country. In the 1970s, there were 17 places in Kentucky where a person could get an abortion if they needed one. Today because of hostile State action, there is only one, and Kentucky isn't alone. Six States have only a single abortion provider, and several more have only two or three. And yet there are efforts in Kentucky, Missouri, and other places to shut down even those last clinics. Like many others, Kentucky's governor, Governor Bevin, has been trying to use bogus health regulations to end abortion care in his State, and he would have been successful, but the sole clinic, EMW Women's

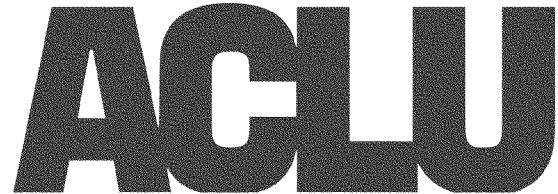
Surgical Center, refused to abandon its patients. Instead, the ACLU and EMW rushed to court to get an emergency order stopping the governor from shutting down the clinic. After trial, the Court found that the governor's regulations "resulted in no benefit to patients." All they would do is make it impossible for a person to get an abortion in the State. But unfortunately, the State appealed, and so the clinic's ability to keep caring for patients remains in jeopardy.

Now, this was a prime strategy used before 2019, using phony health regulations to prevent people from getting abortions. But since Justice Kavanaugh's confirmation, States are increasingly dropping the pretense. Now they are making a claim to what their goal has been along, which is to ban abortion entirely. Now, of course these laws have never been motivated by a concern for women or families. If they were, Georgia wouldn't have one of the highest maternal mortality rates in the country, a rate that is 3 times higher for black women than it is for white women. If they were concerned about women and children, two-third of Alabama counties would not lack a hospital that provides obstetrical care. If they were concerned about children, Alabama wouldn't have one of the highest infant death rates in the country. But instead of addressing these problems, these States are passing blatantly unconstitutional abortion bans.

Now, we must fight those bans and we are, but at the same time, States are also continuing to quietly regulate away abortion access. It is happening in Missouri, which is on the verge of forcing the last clinic in the State to stop providing abortion care. It is happening in Louisiana where, unless the Supreme Court steps in, there will be only a single doctor left in the entire State eligible to provide abortion care. And it is happening in Alabama where but for lawsuits brought by the ACLU on behalf of doctors, like Dr. Robinson, every single clinic in the State would have been forced to close. That is why Congress must pass the Women's Health Protection Act. That bill would safeguard against not only outright bans, but also clinic shutdown laws and other restrictions that prevent people from getting care.

As the mother of two fabulous children, I know that the decision about whether to become a parent is one of the most important ones we make in our lives. It is the job of our government to ensure that we can actually make real decisions, whether that is to continue a pregnancy or to end it, in a way that is best for ourselves and our families. Thank you.

[The statement of Ms. Dalven follows:]



STATEMENT OF

**JENNIFER DALVEN
DIRECTOR, REPRODUCTIVE FREEDOM PROJECT
AMERICAN CIVIL LIBERTIES UNION**

FOR A HEARING ON

THREATS TO REPRODUCTIVE RIGHTS IN AMERICA

BEFORE

**HOUSE JUDICIARY COMMITTEE
SUBCOMMITTEE ON THE CONSTITUTION, CIVIL RIGHTS, AND CIVIL
LIBERTIES**

JUNE 4, 2019

For additional information please contact Georgette Usova, Senior Legislative Counsel, at
gusova@aclu.org

Chairman Cohen, Ranking Member Johnson, and Members of the Committee,

Thank you for holding this hearing and inviting me to testify. My name is Jennifer Dalven and I am the Director of the Reproductive Freedom Project at the American Civil Liberties Union, where I oversee litigation seeking to protect and expand access to abortion and reproductive health care. We are honored to bring that litigation on behalf of abortion providers and their patients, including Dr. Yashica Robinson, an obstetrician-gynecologist from Alabama who is on the panel today as well. I am proud to testify today on behalf of our nearly three million members, activists and supporters.

I have been litigating abortion rights cases for more than two decades and have argued cases throughout the country, including before the United States Supreme Court.¹ I am here to tell you that we are facing a crisis.

In recent months, seven states--Alabama, Georgia, Kentucky, Louisiana, Mississippi, Missouri, and Ohio--have passed extreme laws banning abortion, aimed at prompting the Supreme Court to reverse *Roe v. Wade*.² Legislators in these states, emboldened by President Trump's appointment of two new Justices to the Supreme Court, believe that the newly-constituted Court will take the extraordinary step of actually taking away one of our constitutional rights. While it is important to note that today, abortion is still legal in every state, as these bans have been or will soon be challenged in court and have not taken effect,³ the prospect that *Roe* may be overturned is a very real and very frightening possibility.

However, it's also critical to understand that the Supreme Court doesn't have to overturn *Roe* in order for states to push abortion entirely out of reach. That is because these bans are the culmination of a decades'-long strategy to pile restriction on top of restriction in order to make it nearly impossible for people to get an abortion.

Congress started in on that strategy shortly after *Roe* was decided, when it first attached the Hyde Amendment to an appropriations bill to withhold coverage for abortion for people insured through Medicaid. Representative Henry Hyde openly admitted this was designed to prevent people with low incomes from getting abortions. When he first introduced his amendment in 1976, he said "I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available

¹ *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006).

² 410 U.S. 113, 163-64 (1973). *Roe*'s central holding been applied and reaffirmed repeatedly for over four decades, including in *Planned Parenthood v. Casey*, 505 U.S. 833, 871 (1992), and most recently in *Whole Woman's Health v. Hellerstedt*, 579 U.S. ____ (2016).

³ The laws in Kentucky and Mississippi have been enjoined in cases brought by the ACLU and the Center for Reproductive Rights, respectively. See Alan Blinder, *Federal Judge Blocks Mississippi Abortion Law*, NY Times (May 24, 2019), <https://www.nytimes.com/2019/05/24/us/mississippi-abortion-law.html>. Challenges have also been filed in Ohio and Alabama by the ACLU and Planned Parenthood. The ACLU has also announced its intention to challenge Georgia's ban.

is the...Medicaid bill.”⁴ His plan worked. It is estimated that one in four Medicaid-eligible women seeking an abortion is unable to get one,⁵ which can have devastating consequences for themselves and their families.⁶

State legislatures followed suit, passing a variety of medically unnecessary and politically motivated laws designed to make it impossible for people to access care. This trend picked up alarming speed after the 2010 elections. Since then, states have quietly passed 479 abortion restrictions.⁷ The ACLU is currently challenging more than 30 such restrictions in 14 states. Planned Parenthood and the Center for Reproductive Rights are challenging dozens more.

The laws pushed by abortion opponents include laws known as Targeted Regulations of Abortion Providers (TRAP) that place burdensome requirements on abortion providers that are not placed on other health care providers, such as requirements that they obtain admitting privileges at local hospitals, or that their clinics meet the same standards as ambulatory surgical centers. As courts around the country have found, these laws do not actually make patients safer, and are intended to and do force providers to shut their doors. Indeed, in June 2016, in *Whole Woman’s Health v. Hellerstedt*, the Supreme Court struck down two such Texas requirements noting that although the laws would decimate access to abortion, it “found nothing in Texas’ record evidence that shows that ... the new law advanced Texas’ legitimate interest in protecting women’s health.”⁸

Despite this ruling, not even three years later, the United States Court of Appeals for the Fifth Circuit upheld a nearly identical Louisiana law,⁹ and a petition for review is currently pending before the Supreme Court in that case brought by the Center for Reproductive Rights.¹⁰ That law was patterned after the Texas law and designed to shut down clinics. Indeed, if that law is allowed to stand there would only be a single doctor left in the entire state eligible to provide abortions.

States have also passed a wide range of other laws that create unnecessary obstacles for patients, such as forced ultrasound laws and requirements that patients make unnecessary additional trips to the clinic at least 24 to 72 hours before an abortion. Because TRAP laws have caused many clinics to shut down, patients are often forced to travel hundreds of miles to get to the closest

⁴ Heather Boonstra, *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Policy Review (July 14, 2016), <https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters>.

⁵ Henshaw SK, et. al., *Restrictions on Medicaid Funding for Abortions: A Literature Review*, Guttmacher Institute, 2009, <http://bit.ly/1IK5Xcf>; see also Board of Governors, Federal Reserve System, *Report on the Economic Well-Being of U.S. Households in 2018* (May 2019) at 21, <https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf?smid=nytcore-ios-share> (finding that nearly 40% of Americans would have difficulty covering an unexpected expense of \$400).

⁶ Foster DG, Roberts SCM, and Mauldon J, *Socioeconomic consequences of abortion compared to unwanted birth*, 2012, <http://bit.ly/1PvNd4w>.

⁷ Elizabeth Nash, *Unprecedented Wave of Abortion Bans is an Urgent Call to Action*, Guttmacher Policy Review (May 31, 2019) <https://www.guttmacher.org/article/2019/05/unprecedented-wave-abortion-bans-urgent-call-action>.

⁸ 579 US ____ (2016).

⁹ *June Med. Servs. v. Gee*, No. 17-30397 (5th Cir. 2019).

¹⁰ *June Med. Servs. v. Gee*, Dkt. 18-1323.

abortion provider, posing significant financial and logistical hurdles for patients seeking abortion care, 75% of whom are poor or low-income.¹¹ These requirements mean that a person must attempt to take additional days off work (losing needed income), attempt to arrange and pay for childcare, find and pay for transportation, and, in some cases lodging. It is not uncommon for patients seeking abortion care to have to sleep in their cars overnight near the clinic because they lack the means to stay in a hotel. For many people, these barriers prevent them from obtaining an abortion at all.¹²

In addition, hostile state legislatures have passed laws that would criminalize providers for providing the only generally available method of ending a pregnancy in the second trimester. Like every other court in the country to consider a challenge to such a law, the United States Court of Appeals for the Eleventh Circuit, in a case brought by the ACLU, held Alabama's law was unconstitutional.¹³ However, Alabama has asked the Supreme Court to review that decision.

These are just some examples of the types of laws that state legislatures have passed that make it difficult, and in some cases impossible, for a person who has decided to have an abortion to actually get one. Indeed, these restrictions have so severely eroded access to care that already for many people the right to abortion is more theoretical than real. This is particularly true for people who face multiple barriers to accessing quality health care, including people with low incomes, who are more likely to be people of color, as well as young people and LGBTQ people.¹⁴

Kentucky is a prime example of how severely access has already been limited by the avalanche of restrictions. Shortly after *Roe* was decided, there were 17 locations in Kentucky where a person could get an abortion.¹⁵ Today, there is only a single clinic left standing.¹⁶ Yet Governor Bevin, like many politicians opposed to abortion rights, has attempted to use bogus health regulations to force even that last clinic, EMW Women's Surgical Center, to close. Although the clinic had a transfer agreement with a local hospital signed by the head of the hospital's ob-gyn department, the state argued that it needed an agreement signed by the CEO of the hospital, which it could not get in part due to political pressure from the Governor's office. Refusing to abandon its patients, EMW rushed to court seeking an emergency order to keep its doors open. In the end, the court struck down Kentucky's requirement, finding that the transfer agreement "resulted in no benefit" to patients.¹⁷ All it would do is make it impossible for a person to get an abortion in the state. That case is now on appeal, leaving the clinic's ability to continue seeing patients in jeopardy.

¹¹ Jerman J, Jones RK and Onda T, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>.

¹² See, e.g., *Planned Parenthood of Indiana and Kentucky v. Box*, 896 F.3d 809 (7th Cir. 2018) (cert. pet. pending).

¹³ *West Ala. Women's Ctr. v. Marshall*, 900 F.3d 1310 (11th Cir 2018).

¹⁴ See, e.g., Samantha Artiga et. al., *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017*, Kaiser Family Foundation (Feb 13, 2019), <https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-implementation-of-the-aca-2013-2017/>.

¹⁵ *EMW Women's Surgical Ctr v. Glisson*, 2018 WL 6444391, *9 (Sept. 28, 2018).

¹⁶ *Id.*

¹⁷ *Id.* at *28.

Before 2019, opponents of abortion frequently tried to pretend that restrictions like Kentucky's were put in place to protect women's health. Of course, that claim has always been a farce. After all, some of the states that have passed the most aggressive abortion restrictions also have the most abysmal records when it comes to maternal and infant health outcomes.¹⁸ Georgia has one of the highest maternal mortality rates in the country,¹⁹ with a rate for Black women three times higher than the rate for white women.²⁰ In Alabama, two-thirds of the counties do not even have a hospital that provides obstetrical care.²¹ Alabama also has one of the highest infant death rates in the country.²² The politicians in these states, while focused on banning women's medical decisions, have failed in their duty to ensure that people who want to have babies can be pregnant and give birth safely.

Now, with the most recent bans, states like Alabama and Georgia have dropped the pretense about women's health entirely. They are making plain what their goal *has always been*: to ban abortion entirely.

Americans are rightly incensed by the passage of these laws which expressly force people to stay pregnant against their will. We must fight these bans, and we are. But, while the headlines are focused on the bans, it's important to keep in mind that states are also continuing to quietly regulate away abortion access in the same manner that they have for years.

In fact, medically unnecessary regulations like the one EMW faced in Kentucky are threatening to close clinics throughout the South and Mid-West. Six states today have only a single provider left—Kentucky, Mississippi, Missouri, North Dakota, South Dakota, and West Virginia.²³ Several others have only a handful. And Missouri is at risk of becoming the first state since *Roe* was decided to be without a health center that provides abortions.²⁴ In Louisiana, unless the

¹⁸ See, e.g., Erika Edwards, *States pushing abortion bans have higher infant mortality rates*, NBC News (May 24, 2019), <https://www.nbcnews.com/health/womens-health/states-push-abortion-bans-have-higher-infant-mortality-rates-n1008481>.

¹⁹ Joseph P. Williams, *Limiting Access to Abortion Could Cause Maternal Deaths to Rise*, U.S. News and World Report (May 31, 2019), [²⁰ Georgia Maternal Mortality Report 2014, Georgia Department of Public Health \(March 2019\) \[https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/Maternal%20Mortality%20BookletGeorgia_FINAL_hq.pdf\]\(https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/Maternal%20Mortality%20BookletGeorgia_FINAL_hq.pdf\).](https://www.usnews.com/news/healthiest-communities/articles/2019-05-31/reduced-access-to-abortion-could-lead-to-more-maternal-deaths; see also Maternal Mortality, America's Health Rankings, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/GA (last accessed June 1, 2019).</p>
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²¹ Jessica Ravitz, *Alabama says it wants to protect life. How does that claim stack up outside the womb?*, CNN (May 16, 2019), <https://www.cnn.com/2019/05/16/health/alabama-treatment-offliving/index.html>; *In Rural Alabama, Limited Access To Obstetrics Care*, NPR (May 31, 2015), <https://www.npr.org/2015/05/31/411044409/in-rural-alabama-limited-access-to-obstetrics-care>.

²² Michael Hiltzik, *States with the worst anti-abortion laws also have the worst infant mortality rates*, LA Times (May 15, 2019), <https://www.latimes.com/business/hiltzik/la-fi-hiltzik-anti-abortion-infant-mortality-20190515-story.html>.

²³ Sabrina Tavernise, *'The Time Is Now': States Are Rushing to Restrict Abortion, or to Protect It*, NY Times (May 15, 2019), <https://www.nytimes.com/2019/05/15/us/abortion-laws-2019.html?module=inline>.

²⁴ Reis Thebault, *Judge's order means Missouri hasn't yet become the only state without an abortion clinic*, Washington Post (May 31, 2019), https://www.washingtonpost.com/nation/2019/05/31/missouri-could-become-only-state-without-clinic-perform-abortions-pending-judges-ruling/?utm_term=.481ef653fc51.

Supreme Court steps in in a case brought by the Center for Reproductive Rights, there will only be a single doctor left in the *entire state* eligible and able to provide abortion care.²⁵ In Alabama, but for lawsuits brought by the ACLU on behalf of providers, every single clinic in the state would have been forced to close.²⁶ In Ohio, the state has been slowly going after clinics one by one, using regulation after regulation, to force clinics to shut their doors. And the list goes on.

Although litigation is a powerful tool, we cannot always count on the courts to stop these laws. And, I have seen firsthand the impact on patients. I have seen a clinic have to turn away patients who were sitting in the waiting room when a restriction unexpectedly went into effect. I have seen a clinic unable to care for a patient who had been referred by a hospital in another state because we did not get a court ruling in time. And research tells us that being denied a wanted abortion has serious consequences for people and their families. For example, people who were unable to get a wanted abortion are more likely to experience serious health complications associated with pregnancy,²⁷ to remain tethered to abusive partners,²⁸ and to experience increased economic insecurity.²⁹

In order to ensure that people have not only the theoretical right to abortion but the actual ability to get the care they need, Congress must act. We urge Congress to pass the Women's Health Protection Act, which would provide a powerful federal safeguard against not only outright bans, but also against clinic shut down laws and other restrictions that prevent people from getting the care they need.³⁰ In addition, Congress should pass the EACH Woman Act, which would lift the Hyde Amendment and related bans on abortion coverage in government insurance programs, and also put an end to political interference in private insurance markets by prohibiting federal, state, and local politicians from meddling with insurance companies that choose to cover abortion.³¹ Together, these bills would both keep clinic doors open and make care more affordable. They would protect and expand access for people throughout the country, no matter where they live, how much they make, or what type of insurance they have.

²⁵ *Juno Med. Servs. v. Gee*, Dkt. 18-1323.

²⁶ *West Alabama Women's Ctr. v. Miller*, 299 F. Supp. 3d 1244 (M.D. Ala. 2017); *W. Alabama Women's Ctr. v. Williamson*, 120 F. Supp. 3d 1296, 1317 (M.D. Ala. 2015); *Planned Parenthood Southeast v. Strange*, 33 F. Supp. 3d 1330 (M.D. Ala. 2014).

²⁷ Gerdts C, Dobkin L, Foster DG and Schwarz EB, *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*. Women's Health Issues 25(1):55-59 (Jan. 2016).

²⁸ Roberts SCM, Biggs MA, Chibber KS, Gould H, Rocca CH and Foster DG, *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, BMC Medicine 12:144 (Sept. 2014).

²⁹ Foster DG, Biggs MA, Ralph L, Gerdts C, Roberts S and Glymour MM, *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, Am. J. Public Health 108(3):407-413 (Mar. 2018); *See also Socioeconomic outcomes of women who receive and women who are denied wanted abortions*, ANSIRH Issue Brief (Aug. 2018), www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf (For women denied a wanted abortion, there was an almost fourfold increase in odds that their household income was below the Federal Poverty Level compared to those who were able to obtain a wanted abortion).

³⁰ Women's Health Protection Act, H.R. 2975, 116th Cong. (2019).

³¹ EACH Woman Act, H.R. 1692, 116th Cong. (2019).

There is overwhelming public support for abortion access. According to the recent polling, two-thirds of Americans do not want to see *Roe* overturned.³² And a majority of voters agree that everyone should have health insurance that covers reproductive healthcare, including abortion.³³ They agree that once a person has decided to have an abortion, they should be able to get care that is supportive and affordable without additional obstacles.³⁴

As the mother of two fabulous children, I know that the decision about whether and when to become a parent is one of the most important ones we make in our lives. It's incumbent upon our government to enable us to make these decisions in a way that is best for ourselves and our families. That is critical to ensuring that people and families thrive and that everyone in our community can participate with freedom, dignity, and equality.

³² Jennifer DePinto, *Majority of Americans don't want Roe v. Wade overturned, CBS News poll finds*, CBS News (May 21, 2019), <https://www.cbsnews.com/news/majority-of-americans-dont-want-roe-v-wade-overturned-cbs-news-poll-finds/>.

³³ *New polling shows voters see the impact of abortion coverage on women's economic opportunities and security*, Hart Research Associates (Oct. 18, 2017), <https://allaboveall.org/wp/wp-content/uploads/2017/10/Economic-Opportunity-and-Reproductive-Health-Polling-Memo-October-2017.pdf>.

³⁴ See, e.g., *Analysis of Voters' Opinions on Abortion Restrictions and Affirmative Policies*, PerryUndem Research/Communication (Jan. 20, 2016), https://www.nirhealth.org/wp-content/uploads/2016/01/Memo-NIRH-Poll_Final_3.pdf.

Mr. COHEN. Thank you. Our next witness is Dr. Yashica Robinson, attending physician in the Department of Obstetrics and Gynecology at the Alabama Women's Wellness Center of Huntsville, Alabama, where she has worked since 2005. She is a fellow of the American Congress of Obstetricians and Gynecologists and a National Health Service Corps Scholar from 2000 to 2013. She received her M.D. from Morehouse School of Medicine, a recipient of three scholarships. She has a B.A. in chemistry, magna cum laude, from Talladega College. She did her residency in obstetrics and gynecology at the University of Alabama School of Medicine.

Dr. Robinson, thank you, and you are recognized for five minutes.

STATEMENT OF YASHICA ROBINSON

Dr. ROBINSON. Thank you. Thank you, Chairman Cohen, Ranking Member Johnson, and members of the subcommittee. My name is Dr. Yashica Robinson. I serve on the board of Physicians for Reproductive Health and I am an obstetrician-gynecologist in Alabama. I have a busy obstetrics practice where I provide prenatal care, deliver babies, and treat mothers after they have given birth. I also provide abortion care at Alabama Women's Center.

I provide abortion care because I believe that patients deserve the full spectrum of care. I came to this work because of my passion for young people that is deeply connected to my personal experience as a teen mother. Prior to finishing high school I learned that I was pregnant, and as a result of fear and lack of resources, by the time I confided in my mother and grandmother, I had no choice—I was going to be a mother.

Becoming a mother as a teenager came with many harsh realities. I love my children dearly, but I know that everyone should be able to make that decision for themselves. I have been in the shoes of many of the young people that I see in my clinic, and it is important for them to know that regardless of their decision, that I am here to support them.

Providing abortion care in Alabama is challenging, but it is also deeply satisfying. I am proud to provide compassionate, quality care when patients enter our doors, but I know all too often that getting to our doors comes with many unnecessary obstacles. People have to travel long distances to come to our clinic. They receive outdated state-mandated information, and then they are required to wait an additional 48 hours before I can provide them the care they need.

Low income patients have an exceptionally hard time. These obstacles increase the overall cost of care, including costs related to transportation, lodging, missing work, and child care. I know that patients have slept in their cars overnight because they had no other options.

Alabama also has a 20-week abortion ban, and patients needing care after that point have to travel out of state, which further increases costs. And young people have to navigate an onerous, time-intensive process to have an abortion if they cannot involve a parent. I have cared for a 12-year-old who faced numerous delays before getting the final judicial approval necessary to proceed with the abortion she needed. Though I met her in her first trimester

of pregnancy, she was well into the second trimester and nearly at the legal limit for being able to obtain an abortion in the State of Alabama by the time she navigated all of these hurdles.

The near total ban on abortion that recently passed in Alabama, H.B. 314, imposes a 99-year prison sentence for a physician unless it is agreed that the abortion is needed for the necessary for the life or meets an extremely narrow exception for the health of the woman. This ban, should it ever go into effect, would be disastrous for Alabamians. H.B. 314 is blatantly unconstitutional and would force doctors like me to choose between what is ethically, medically appropriate care, and being criminalized. There is no other area of medicine where we have legislation threatening physicians with criminal prosecution for simply doing their jobs.

Alabama is already a state with an unconscionably high maternal and infant mortality rate. Nearly two-thirds of Alabama counties lack hospitals that offer obstetrical care. Moreover, the number of pregnancy-related deaths across the country is steadily increasing, and in Alabama, black women are nearly five times more likely to die of pregnancy-related complications than white women. Without access to safe abortion care, maternal mortality rates will rise even more.

By attempting to criminalize abortion providers we endanger women and we harm communities that are already lacking health care providers. This law will make doctors' often split-second judgment calls potential criminal acts. This lack of autonomy may deter new physicians from coming to areas that already have a shortage of physicians and may cause others to leave.

Alabama legislators made it very clear, their ultimate goal is to outlaw abortion, period. This is dangerous, as the consequences extend far beyond that. It will affect all providers who take care of pregnant women, not just abortion providers. Women and their doctors need to have access to the full spectrum of care as they manage undesired and complicated pregnancies. Regardless of how you feel about abortion, we cannot tie the hands of health care providers.

Though H.B. 314 has not taken effect it is negatively impacting patients already. I wish that you all could hear how worried patients are. One young lady told me of the nightmares that she had prior to coming in to the clinic because she felt that she would be denied services because of these restrictive laws. In addition to legal obstacles, providers and patients face constant harassment. To enter the clinic or my obstetrics practice, patients have to walk through a line of protestors who yell hateful, dehumanizing, sometimes racially charged things. The hostility that we endure is completely unacceptable and has gotten worse in the past few years. Recently, a protestor attempted to run over a volunteer with their vehicle. Needless to say, this harassment is unheard of for my colleagues who work in other fields of medicine.

The bottom line is this: abortion is health care. Alabamians deserve better. I urge elected officials to show empathy for the lived experiences of people who need health care, be it abortion, miscarriage management, or prenatal care, for they are all connected. Health care should remain patient-centered, and all medical deci-

sions should remain between a patient and her physician, without any political interference.

Thank you.

[The statement of Ms. Robinson follows:]

Testimony of Yashica Robinson, MD before the House Judiciary Committee Subcommittee on
the Constitution, Civil Rights, and Civil Liberties
June 4, 2019

Good morning Chairman Cohen, Ranking Member Johnson, and members of the Subcommittee. My name is Dr. Yashica Robinson, I serve on the board of directors of Physicians for Reproductive Health. I am very happy to have the opportunity to speak with you today. I'm an obstetrician-gynecologist in Huntsville, Alabama. I have a busy obstetrics practice where I provide prenatal care, deliver babies, and treat mothers after they give birth. I also provide abortion care at Alabama Women's Center in Huntsville. I provide abortion care because I believe patients deserve the full spectrum of care. However, it is extraordinarily difficult for many people in Alabama to access abortion services, and it will only get worse as women's rights and access to abortion care continue to be threatened.

I came to this work because of my passion for young people, one that is deeply connected to my personal experience with teen pregnancy. Prior to finishing high school, I learned I was pregnant. As a result of fear and lack of resources, by the time I confided in my mother and grandmother, I had no choice—I was going to be a mother. Becoming a mother as a teenager came with many harsh realities. I love my children with all my heart, but I know that everyone should be able to make the decision to parent for themselves. I have been in the shoes of many of the young people I see in my clinic, and it's important for them to know that regardless of their decision, that I am here to support them.

Providing abortion care in Alabama is challenging, but also deeply satisfying. I am proud to provide patients with compassionate, quality care when they enter our doors, but I know all too well that getting to our doors comes with too many unnecessary obstacles. Abortion clinics are being forced to close at an alarming rate. People have to travel long distances to come to our clinic. They receive outdated state mandated information, then they are required to wait an additional 48 hours before I can provide the care they need. Low income patients have an exceptionally hard time. Alabama prohibits public funding for abortion, so people with Medicaid have no coverage for abortion care. State law also restricts private insurance coverage of abortion and allows employers to deny insurance coverage for reproductive health services, making abortion unaffordable for too many people. These politically sanctioned obstacles increase the overall cost for care, which also includes costs relating to transportation, lodging, missing work, and childcare. I know of patients who have slept in their cars because they have no other options.

Alabama also has a ban on abortion after 20 weeks gestation. Patients needing care after that point have to travel out of state, making the care even more expensive. And young people have to navigate an onerous, time-intensive process to have an abortion if they cannot involve a parent. I have cared for a 12yo victim of incest who faced so many obstacles and delays before getting the final judicial approval necessary to proceed with the abortion she needed. Though I met her in her first trimester of pregnancy, she was well into the second trimester and nearly at

the legal limit for being able to obtain an abortion in the state of Alabama by the time she navigated all of these hurdles.

The National Academies of Sciences, Engineering and Medicine (NASEM) published a comprehensive study concluding that abortion is extremely safe and finding that the biggest threat to patient safety is the litany of medically unnecessary regulations that raise costs and delay procedures, ultimately putting women's health at risk. They confirmed what we already know: that access to safe abortion care all too often depends on where you live and your socioeconomic status.

Over the years, Alabama Women's Center has been forced to comply with onerous, medically-unnecessary building requirements—similar to those that were held unconstitutional by the Supreme Court in 2016 in the *Whole Women's Health v. Hellerstedt* case. The local anti-abortion group even sued the zoning board to try to force us to close. This same group then drafted legislation making it illegal to operate an abortion clinic within 2,000 feet of a school—another law specifically designed to shut our facility down. A federal district court held that law unconstitutional, as well, recognizing it was nothing more than a thinly veiled attempt to try to push abortion out of reach for patients. And this is just a small sample of the politically-motivated restrictions we have to contend with.

The near total ban on abortion that recently passed in Alabama, HB 314, imposes a 99-year prison sentence for a physician determined to have caused an abortion, unless it is agreed the abortion is necessary for the life or meets an extremely narrow exception for the health of the woman. This ban, should it ever go into effect, would be disastrous for Alabamians. HB 314 is blatantly unconstitutional and would force doctors like me to choose between what is ethical, medically appropriate care, and being criminalized. There is no other area of medicine where we have legislation threatening physicians with criminal prosecution for doing their jobs.

Alabama is already a state with unconscionably high maternal and infant mortality rates. According to the Alabama Department of Public Health (ADPH) nearly two-thirds of Alabama counties lack hospitals that offer obstetrical care. Moreover, the number of pregnancy-related deaths across the country has steadily increased. In Alabama, Black women are nearly five times more likely to die from pregnancy-related causes than white women. There are many pre-existing conditions that can be made worse by pregnancy, and other serious health conditions can be caused by pregnancy. We know that racial disparities in health care are exacerbated by policies that make accessing health care more challenging. Without access to safe abortion, maternal mortality rates will rise even more.

By attempting to criminalize practitioners who provide abortion care, we will have the unintended consequence of endangering women and harming communities that are already suffering from lack of health care providers. This law will make doctor's (often) split second judgment calls potential criminal acts. This law compounds the complex scenarios that obstetricians routinely balance as they try to make the best decisions they can about managing

complicated pregnancies. The lack of autonomy that this law imposes on physicians may deter new physicians from coming to areas that have a shortage of physicians and may cause others to leave. Alabama legislators made it very clear, their ultimate goal is to outlaw abortion, PERIOD. This is dangerous, as the consequences extend far beyond that. It will affect ALL providers who take care of pregnant people, not just abortion providers. Abortion care is health care and pregnant people and their doctors need to have access to the full spectrum of options as they manage undesired or complicated pregnancies. Regardless of how you feel about abortion, we cannot tie health care providers' hands because of individuals' objection to a medical procedure for political gain.

Though HB 314 has not taken effect, it is negatively impacting patients. I wish you all could hear how worried patients are. One told me of the nightmares she had prior to coming to the clinic about being turned away and denied services because of these restrictive laws.

In addition to legal obstacles, providers and patients face constant harassment. To enter either Alabama Women's Center or my obstetrics practice, patients have to walk through a line of protestors who yell hateful, dehumanizing, sometimes racially charged things. The hostility and intimidation we endure is unacceptable and has only gotten worse in the past few years. Recently, a protestor attempted to run over a volunteer with their vehicle. Thankfully, the volunteer is okay, but this underscores the security concerns for abortion providers in the South. Needless to say, this harassment is unheard of for my colleagues who work in other fields of medicine.

The bottom line is this: Abortion care is healthcare! Alabamians deserve better. I urge elected officials to stop trying to make it harder for people to access full spectrum health care. Instead, show empathy for the lived experiences of many Alabamians and people in other states who continue to need health care—be it abortion, miscarriage management, or pregnancy care, for they are all connected. All aspects of healthcare should remain patient-centered, and medical decisions should remain between the patient and her physician, without political interference.

Thank you.

Mr. COHEN. You are welcome. I notice several of you seem shocked by the—we are used to it here. It was the ghost of Shirley Chisholm expressing her upset about the need for this hearing. [Laughter.]

Mr. COHEN. Now I would like to recognize H.K. Gray, who is an activist with Youth Testify, a program for the Advocates for Youth and the National Network of Abortion Funds. She wrote an opinion piece in Teen Vogue on abortion rights.

You are recognized for five minutes.

STATEMENT OF H.K. GRAY

Ms. GRAY. Good morning and thank you to the chairman and ranking member for this opportunity to share my story and bring to light the very real ways restrictions to abortion access threaten our ability to make autonomous reproductive health decisions and raise the families we want.

My name is HK Gray. I am 18 years old and I came here today all the way from Fort Worth, Texas. I am an activist with Youth Testify, a leadership program through Advocates for Youth and the National Network of Abortion Funds. It is an honor to be able to speak before you today.

I became pregnant for the first time when I was 15 and had my daughter shortly after I turned 16. Immediately upon finding out I was pregnant, I knew I would continue the pregnancy. Despite a bit of preterm labor, my baby arrived right on time. She is in her terrible twos now and I love her. I am fortunate to have the incredible support of my fiancé, but becoming a parent has also had challenges, like losing my friends and not being able to attend school. I have been on my own for a few years now because my father is homeless and my mother was incarcerated. They weren't in situation to support me legally, financially, or emotionally. I know they love me, but they are unable to parent me the way I need them to, and the State requires.

After having my daughter, I tried to get a Paragard IUD, but I was unable to because in Texas, in order to get birth control, I need my parent's consent, something I couldn't get due to my parents' situations. And although my doctor was sympathetic, she couldn't legally give it to me.

A few months later, I became pregnant again, but I miscarried. Ten months after giving birth to my daughter, I realized I was pregnant for a third time. When I told my fiancé, we both knew what the other was feeling. We couldn't afford a second child, and it was harder when I had to go back to work a week after having my daughter because I didn't have paid parental leave. Adoption wasn't the right decision for us because if I continued the pregnancy I would have wanted to parent, and the WIC, SNAP, and Medicaid programs aren't enough as it is.

When I tried to get an abortion, I didn't realize how hard it would be. Texas requires parental consent for anyone under 18 years old. It is not that my parents would have opposed to my decision, it is that they weren't physically able to give the consent. This was a new concept to me because it is something I didn't have to do when I had my daughter. It seemed weird to me that I didn't need anyone's permission to become a parent, but I needed to prove

to the state that, as a parent, I was mature enough to not have another child.

Thankfully, I found Jane's Due Process, an organization that helped me find a clinic and connected me to a lawyer who would walk me through the judicial bypass process. I had to get an ultrasound to take to court and prove how far along I was.

A few weeks later, when I finally went to court, it was a long day and honestly it was very hard on me. The judge said some hurtful things about me being sexually active, being a young parent, and wanting an abortion. I felt shamed no matter which decision I made. The judicial bypass process is a burden and barrier to abortion access.

My actual abortion was pretty straightforward. The providers were kind and treated me like an adult, and I was glad to get back home to care for my daughter. The irony of this whole experience is that I could make medical decisions for my daughter, but not for myself. When I take my daughter to see a doctor, I am treated like an adult, but I couldn't get routine care at the dentist or get birth control without my parents' permission.

I believe we need more support in this country for young women and transgender people who want to be able to access birth control or want to parent, or want an abortion, or like me, needed all of those things at different times in my teenage years.

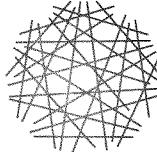
Government restrictions on abortion hurt those of us who have fewer resources, or people of color or undocumented or living with disabilities or poor or queer. In Texas, the State prohibits all types of health insurance from covering abortion care and we have to pay out of pocket. I couldn't afford my abortion, but thankfully a family member lent me the money.

Like me, most people seeking abortions are already parenting and are balancing paying for child care, food, and rent. In Texas, 96 percent of counties do not have abortion clinics, impacting nearly half of Texas women. We have to figure out how to take time off work or school to travel to get an abortion, find some place to stay, and pay for all. We are forced to listen to government-mandated, medically inaccurate counseling, and wait 24 hours and go to the doctor twice before getting an abortion.

Unlike me, the majority of people who have abortions are people of color, and we must respect their decisions. I wish there was more support for people of color who are impacted by these restrictions harder than I am. We need more love and compassion for families and young people like me. I had a child, I had a miscarriage, and I had an abortion.

As we say at the National Network of Abortion Funds, "Everyone loves someone who had an abortion." Thank you for your time. I hope my story helps you remember these laws that you pass impact your constituents, like me, and your loved ones who have had abortions.

[The statement of Ms. Gray follows:]



NATIONAL NETWORK OF
ABORTION FUNDS

June 3, 2019

VIA ELECTRONIC TRANSMISSION

Testimony submitted to House Committee on the Judiciary Subcommittee on the Constitution, Civil Rights, and Civil Liberties

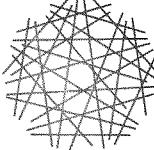
Good morning and thank you to Chairman Cohen and Ranking Member Johnson for this opportunity to share my story and bring to light the very real ways restrictions to abortion access threaten our ability to make autonomous reproductive health decisions and raise the families we want.

My name is HK Gray. I am 18 years old and I came here today all the way from Fort Worth, Texas to share my abortion story with you. I am an activist with Youth Testify, a leadership program through Advocates for Youth and the National Network of Abortion Funds. It is an honor to be able to speak before you today.

I became pregnant for the first time when I was 15 and had my daughter shortly after I turned 16. Immediately upon finding out I was pregnant, I knew I would continue the pregnancy. Despite a bit of preterm labor, my baby arrived right on time. She's in her terrible twos now and I love her. I am fortunate to have the incredible support of my fiancé but becoming a parent has also had challenges, one of the hardest parts, for me, was losing my friends and not being able to attend school. I've been on my own for a few years now because my father is homeless and my mother was incarcerated. They weren't in a situation to support me legally, financially, or emotionally. I know they love me, but they're unable to parent me the way I need them to, and the state requires.

After having my daughter, I tried to get a Paragard IUD, but I was unable to because in Texas, in order to get birth control, I need my parent's consent -- something I couldn't get due to my parents' situations. And, although my doctor was sympathetic, she couldn't legally give it to me. It was an awkward conversation; here I was a parent, but I needed my own parents in order to get healthcare to prevent an unintended pregnancy. These ridiculous legal barriers made it so my doctor wasn't able to provide me with the birth control best for my situation and, of course, led me to need my abortion.

A few months later, I became pregnant again, but I miscarried. Ten months after giving birth to my daughter, I realized I was pregnant for a third time. When I told my fiancé, we both knew what the other was feeling. We couldn't afford a second child, let alone go through an entire pregnancy. It was hard enough when I had to go back to work a week after having my daughter because I didn't have paid parental leave. Raising a child is a joy, but it's also expensive and challenging. I was just starting to get the hang of raising my daughter, and wasn't ready for another. Adoption wasn't the right decision for us because if I were to continue the pregnancy, I would have wanted to raise my child and I simply couldn't afford it. The WIC, SNAP, and Medicaid programs aren't enough as it is. We decided that an abortion was the right decision for us.



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When I tried to get an abortion, I didn't realize how hard it would be. Texas requires parental consent for anyone under 18 years old. It's not that my parents would have opposed to my decision, it's that they weren't physically able to give the consent. This was a new concept to me because it's something I didn't have to do when I had my daughter. It seemed weird to me that I didn't need anyone's permission to become a parent, but I needed to prove to the state that, as a parent, I was mature enough to *not* have another child.

So, I started the process of getting a judge's approval through a judicial bypass which was long and complicated. I found Jane's Due Process an organization that helped me find a clinic and connected me to a lawyer who would walk me through the process. I had to get an ultrasound to take to court and prove that I was pregnant and how far along I was. My lawyer explained the process and we started discussing my story to build my case; we talked about what kind of mom I am, the situation with my parents, and why I needed an abortion.

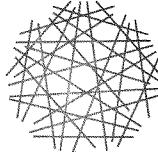
A few weeks later, when I finally went to court, it was a long day and honestly it was very hard on me. The judge said some hurtful things about me being sexually active, being a young parent, and wanting an abortion. I felt shamed no matter which decision I made.

The whole ordeal took over two hours. It was frustrating that it was weeks after I first tried to get an abortion. Forced parental involvement laws create extra barriers to abortion access and cause delays and increase the costs we pay for an abortion. The judicial bypass process is a burden and barrier to abortion access.

My actual abortion was pretty straightforward. The providers were kind and treated me like an adult, and I was glad to get back home to care for my daughter. The irony of this whole experience is that I could make medical decisions for my daughter, but not for myself. When I take my daughter to see a doctor, I'm treated like an adult, but I couldn't get routine care at the dentist or get birth control without my parents' permission.

I believe we need more support in this country for young women and transgender people who want to be able to access birth control or want to parent or want an abortion, or like me, needed all of those things at different points in my teenage years. We should be respected and trusted no matter what decision we make. Young people deserve to be heard and deserve to be leaders on reproductive health, rights and justice issues. We can tell you about all the barriers in this country, because they hit us hard.

Government restrictions on abortion hurt those of us who have fewer resources. The restrictions are harder on those who are people of color or undocumented or living with disabilities or poor or queer. It makes our abortions more expensive and makes it hard to navigate logistics. In Texas, the state prohibits all types of health insurance from covering abortion care. This means each Texan seeking an abortion must pay out of pocket. I couldn't afford my abortion, but thankfully a family member lent me the money. Like me, most people seeking abortions are already parenting and are balancing paying for child care, nutritious meals for our families, and rent. Texans seeking abortions know all about the logistical and financial challenges that come along with abortion restrictions because some 96% of counties do not have clinics that provide abortions, and nearly half of Texas women live in those counties. We need to



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not only figure out how to take time off work or school to travel to get an abortion, arrange that travel, find someplace to stay, and how to pay for all those extra expenses. We are also forced to listen to government-mandated medically inaccurate counseling, and wait 24 hours and go to the doctor twice before getting an abortion. These restrictions harm our ability to make decisions about our families that are right for us. I wish our government would create policies that make it easier for us to raise healthy families in safe communities. I wish there was more support for young parents like me; the laws as it is make it hard to have an abortion, but also make it hard for me to raise my daughter. Unlike me, the majority of people who have abortions are people of color, and we must respect their decisions. I wish there was more support for people of color who are impacted by these restrictions harder than I am.

We need more love and compassion for families and young people like me. I had a child, I had a miscarriage, and I had an abortion. As we say at the National Network of Abortion Funds, "everyone loves someone who had an abortion." Thank you for your time and I hope my story helps you remember these laws that you pass impact your constituents, like me, and your loved ones who have abortions.

Mr. COHEN. Thank you, Ms. Gray.

We will now enter the period of our hearing where each member has five minutes to ask questions, and I will begin by recognizing myself for five minutes.

Dr. Phillips, thank you for traveling here from Memphis, and away from the land of the best barbecue in the world to join us today. You have spoken about how some of Tennessee's laws, such as the 48-hour waiting period, make it difficult for women to obtain an abortion, particularly those who have to travel long distances for multiple visits.

You have also spoken about how your hospital has bowed to local pressure and placed severe limits on access to abortion. What are those limits and how have they affected patients in your care?

Dr. PHILLIPS. Thank you. The hospital that I practice in has relatively arbitrarily limited abortion to the case of rape, incest, and save the life of the mother. The issue is that the medical indication of saving the life of the mother is one that requires a great number of events to happen to actually prove, and to document more than just prove.

So we have delays. Cases have to be referred to the administration to consider. Many times there requires a number of medical opinions to be documented, and in the meantime the pregnancy is advancing and advancing. And even though first and second trimester abortions are safe, certainly safer than having a baby, and certainly under these medical circumstances safer than having a baby, the delays are heart-wrenching for the patient and for their families as they wait. This is one of the big issues that we face all the time.

Mr. COHEN. Ms. Dalven, Dr. Phillips mentioned the three exceptions that are generally in the law—rape, incest, or the life of the mother. In your knowledge of laws in the United States, do most states now see those three exceptions, except for these new wave of laws that do not consider those exceptions?

Ms. DALVEN. You are absolutely right that many of the new State bans lack exceptions for rape and incest. That is certainly true and the public is outraged. The public is outraged by the bans themselves as they affect all women, and that is why we saw people take to the streets in more than 500 cities and towns around the country, in the middle of the week, to express how concerned they were about bans like Alabama's and Ohio's and Kentucky's and Georgia's, where we are seeing politicians increasingly step away from this old argument that they were just trying to protect women's health or just trying to ensure that decisions are informed. Now what we are seeing is people just taking this decision entirely out of the hands of women.

Mr. COHEN. It is interesting that with the exception of Ohio, the states that have been the worst on these laws are the same states that had miscegenation laws, the same states that made it difficult to vote and were suspect states in the Voting Rights Act, and left the country—somewhat unpatriotic of them.

Professor Murray, you have explained in your testimony that the reasoning Roe v. Wade was part of a long line of cases recognizing a right to privacy and a right to make one's own personal decision in certain areas of life, including people's choice of who they might

want to marry, same sex, et cetera, and the rights of parents to direct the upbringing of their children. If Roe were overturned, in what ways could those other rights be threatened?

Ms. MURRAY. Chairman Cohen, you are absolutely right that Roe v. Wade proceeds from a long provenance of cases. It was not conjured out of whole cloth but rather proceeds from a series of decisions that were enacted in the 1920s, Meyer v. Nebraska, Pierce v. Society of Sisters, all of which held that parents have the right to upbringing of their children and upbringing of their choosing.

From those protections, we get Griswold v. Connecticut, the right to privacy and the right to use contraception. From there we have Roe v. Wade and from there we have Lawrence v. Texas, the right to engage in consensual adult sexual relationships; and then from there, Obergefell v. Hodges in 2015, which affirms the right to marry a person of the same sex, and, of course, as you say, 1967, Loving v. Virginia. All of these are predicated on the same judicial founding, and if Roe falls, all of these other decisions are equally imperiled.

Mr. COHEN. Thank you, Professor Murray. It is scary to think that we could go back to that era, and all those things that we consider rights and advancements would fall, and we would be back in the Dark Ages.

I recognize the ranking member for five minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

We have heard some compelling testimony today. It is heartfelt on both sides, and we expected that, and I appreciate the civil tone of the dialogue. It is important for us, as American people.

Look, there is a gallery full of young people here today, and I just want to say one thing before I get to my questions. I want to encourage all of you to examine the evidence for yourself. I had an eighth-grade teacher one time that told me that what is popular isn't always right and what is right isn't always popular, and you owe it to yourself to do your own homework.

One of the majority witnesses today said something that really struck me. She said, quote, "I am a human being that deserves autonomy in this country that calls itself free." Okay, but review the facts for yourself and you will see that the indisputable scientific evidence now shows us that when a human sperm meets and fertilizes a human egg, at the moment of conception, there becomes an unborn, living, genetically distinct and biologically self-directing human being. The question is, you should ask yourself quietly, why shouldn't each of those human beings deserve autonomy in this country that calls itself free?

Let me get to my questions. Ms. Bennett, thank you for being here. Your testimony is compelling, and I appreciate you including in your statement Supreme Court Justice Clarence Thomas' concurring opinion in the Box case.

I wanted to read a quick excerpt from that opinion. He said, quote, "This case highlights the fact that abortion is an act rife with the potential for eugenic manipulation. From the beginning, birth control and abortion were promoted as a means of effectuating eugenics. Planned Parenthood founder, Margaret Sanger, was particularly open about the fact that birth control could be used for eugenic purposes. These arguments about the eugenic po-

tential for birth control apply with even greater force to abortion which can be used to target specific children with unwanted characteristics.

“Even after World War II, future Planned Parenthood president, Alan Guttmacher, and other abortion advocates endorsed abortion for eugenic reasons and promoted it as a means of controlling the population and improving its quality. A growing body of evidence suggests that eugenic goals are already being realized through abortion.”

Then he says this: “Eight decades after Margaret Sanger’s ‘Negro Project,’ abortion in the U.S. is also marked by considerable racial disparity. The reported nationwide abortion ratio, the number of abortions per 1,000 live births among black women is nearly 3.5 times the ratio for white women.”

Continuing to quote Justice Thomas, “And there are areas in New York City in which black children are more likely to be aborted than they are to be born alive, and they are up to eight times more likely to be aborted than white children in the same area.”

The question is, why do you believe the black community is being targeted by the abortion industry?

Ms. BENNETT. Thank you for the question. If you look at the history of the American Birth Control League, which later became Planned Parenthood, you will see that Margaret Sanger had this pseudoscience that she believed in eugenics philosophy, and it wasn’t just her. It was also members of her board. One of her board members was named Lothrop Stoddard and he had a book called “The Rising Tide of Color Against White Supremacy”, and it was all about how mixed races were growing and that was a threat to white supremacy.

You have to ask yourself, what would a man like that, who wrote a book like that, why would he be interested in the birth control movement, particularly with targeting people of color? It was because they believed that certain people groups should prosper and grow and that would be a betterment to society, and other groups should not. And that was seen clearly in the writings of Margaret Sanger when she talked about people of color like weeds that should be exterminated.

And she also had something called the Negro Project, in which she manipulated, you know, black ministers and people of color to go into their communities and to push birth control. Unfortunately, she also pushed sterilization. There are women today, like an African American friend I have, Elaine Riddick, who was sterilized in North Carolina after having one child. And she was told by doctors, “We don’t want you to reproduce after your own kind.”

America has a dark history, and it involves racism. And now we see 78 percent of abortion facilities, Planned Parenthoods, are located in lower-income, minority neighborhoods. There is a great resource on protecting black life where they lay out the map of the United States, and you can go to that website and you can see the different areas that are targeted.

And this is why people of color are standing up. The Church of God in Christ is the largest black denomination in America with over six million members, and recently they have started a movement to stand up against the targeting of African American com-

munity as well as a movement of adoption, encouraging their members to adopt.

I will also say that African American women, being three times more likely to abort, it is not because we desire to have abortions more than anyone else. It is because we often feel like we don't have the resources, we don't have the support that we need.

And so things do need to change. We do need help and I support in these areas. People should not be pressured like my mom was. People should not feel like they have to choose abortion because they don't have the resources to take care of themselves or to take care of their families. And so a lot has to change in order for us to truly be able to have equality in this country and not be targeted because of our lack of resources and who we are.

Mr. JOHNSON. I greatly regret that I am out of time but I yield back. Thank you.

Mr. COHEN. Thank you, Mr. Johnson.

Mr. Nadler, you are recognized for five minutes.

Mr. NADLER. Thank you. Professor Murray, there has been some suggestion, more than a suggestion, this morning, that efforts to provide abortion care are linked to an agenda based on eugenics and our design to control minority populations. As someone who has studied the history of reproductive rights in this country, what is your response to that argument?

Ms. MURRAY. I am really grateful to have the opportunity to clarify the record. Like Ms. Bennett, I, too, have studied this history, and she is absolutely correct that the history of eugenics of this country is laced with the taint of racism, but it goes in both directions. Not only was eugenics used to promote the use of contraception and sterilization, it was also used to promote abortion, but from the other side.

In the 1800s, when the first laws criminalizing abortion were enacted, it was because of nativist anxieties that native-born white women were not having as many children as their darker-hued immigrant sisters, who were having too many. So the early effort to criminalize abortion is actually part of a vestige to overwhelm immigrant populations with native-born white births.

I will also note, in response to Ms. Bennett's testimony, that adoption is an option but African American children are the ones who are most likely to linger in the child welfare system and in foster care, and are the least likely to be adopted.

Thank you.

Mr. NADLER. And it is true that eugenics is also a motivating factor, is it not, in much of the anti-immigration legislation? We have got to keep out the Jews, the Italians, the Slavs, and other Eastern Europeans in the early 20th century. Is that not the case?

Ms. MURRAY. That is the case. My colleague at Berkeley, Jerome Karabel, documents some of that in his accounts of higher education in the United States.

Mr. NADLER. Thank you. Last November, a Federal judge blocked Mississippi's ban on abortion after 15 weeks, ruling it was unequivocally unconstitutional. The court described that law as closer to the old Mississippi, a Mississippi bent on controlling women and minorities.

You have already spoken about how restrictions on access to abortion fall disproportionately on women of color. Could you describe some ways in which an outright ban on access to abortion would impact women of color and other vulnerable populations, Professor?

Ms. MURRAY. Women of color continue to bear the brunt of the burden of the restrictions on abortion access. They are often the most likely to be victims of economic insecurity and will not have the opportunity to travel, to go to places where they are able to get more liberalized access to abortion. They will also be more likely to have employment insecurity and not be in positions where they can take time off of work. They may also already be mothers to children and will have difficulty obtaining child care in order to comply with the waiting period and things of that nature.

All of this is compounded by African American women's limitations in access to health care, the high rate of maternal morbidity in this country, and the high rate of infant mortality among African American children.

Thank you.

Mr. NADLER. And, Professor, the judge in that case also wrote that "the State's professed interest in women's health care is pure gaslighting," unquote. This judge recognized a pretext for what it is. But now the case is on appeal to the Fifth Circuit, a court that is conservative to begin with, and now has five extreme right-wing judges appointed by President Trump.

What are some of the ways in which judges who want to reach a particular political outcome could twist the facts in cases involving restrictions on access to abortion?

Ms. MURRAY. Well, Chairman Nadler, we have already seen episodes where courts have consistently flouted the extant precedents of the Supreme Court. So in *Whole Woman's Health v. Hellerstedt* in 2016, this court struck down a Texas admitting privileges law that basically helped close a number of clinics in Texas. It was struck down in that case.

Almost immediately after, the State of Louisiana passed a virtually similar admitting privileges law. Again, as we have heard today, these admitting privileges laws are often unnecessary in the case of abortion because abortion providers don't often have to admit their patients to hospitals because the procedure is so safe. So we have already seen, in that Louisiana case, *Juno Medical Services*, which is currently pending on cert before the Supreme Court, an effort by the Fifth Circuit, again, to flout the precedents that this court has articulated.

Mr. NADLER. Thank you. Ms. Dalven, most State legislatures that are imposing extreme restrictions on abortion or outright bans are targeting the doctors for criminal penalties rather than the patients, although President Trump slipped up during the campaign. He said patients should be arrested and jailed. It is apparently no longer acceptable to say you will put women in prison for receiving an abortion. Can you describe why these laws would still end up punishing women who seek abortions?

Ms. DALVEN. It would—it can punish women in multiple ways. First, if there is no constitutional right to abortion, if the Supreme Court were to overturn *Roe v. Wade*, there would be nothing to

stop states from going after women and punishing women. The fact that they are not saying that today doesn't mean that they will not say that tomorrow.

Second, these laws do punish women by preventing them from getting the care that they need. These laws, a ban on abortion, is a punishment for a woman who needs one. And we know, in states like Georgia and Alabama, it is particularly galling. These states have some of the highest maternal mortality rates in the country. These are states that lack appropriate health care. They lack OB-GYNs, they lack obstetrical departments, and Georgia is one of the states in this country who has refused to expand Medicaid coverage to ensure that people can get the health care that they need.

So bans on abortions, forcing people to stay pregnant against their will, is a punishment, aside from the criminal punishment that could befall women if Roe is overturned.

Mr. NADLER. Let me ask one further question. If a court adopted a constitutional analysis that bans an abortion, perfectly okay because majorities don't like them, is there any difference that would prevent, constitutionally, a state from passing a ban on blood transfusions or open heart surgery, for example? Is there any juridical difference?

Ms. DALVEN. That is a question I have not considered but it would certainly be concerning if the State could step in and say that—and take medical practice out of the hands of doctors and ensure that—and prevent patients from getting the care that they need.

Mr. NADLER. Thank you. My time has expired.

Mr. COHEN. Mr. Gohmert, you are recognized for five minutes.

Mr. GOHMERT. Thank you, and I have been very pleased to hear some things made by our full committee chairman in this hearing, like the statement that is made, or the question, because I recall President Obama saying, in the White House town hall meeting, that under his Obamacare program a woman who had gotten a pacemaker that kept her alive for over a decade, the best thing would just give her a pain pill. So am glad to know that he now believes the State should not prevent someone like that from getting the health care they need.

Ms. Ohden, it is good to see you again. I am curious. You shared in your testimony your birth mother's abortion was forced upon her. Have you heard of any other cases where potential birth mothers, or women that are talking about a potential abortion, had to deal with pressure to get an abortion?

Ms. OHDEN. Thank you for your question. It is correct. My biological mother, I now know, was forced to have this abortion. I didn't find that out until about six years ago now. My birth mother is now a huge part of my life. She is a great support to me. But I face the reality every day of the fact that not only was my life supposed to end but this is not something she wanted.

And I know that she is not alone in that. There was a study done recently where 48 of women identified being coerced into their abortion. And again, I just want to thank all of the women for being here today. I know we have differing experiences and different opinions, but I think we are all passionate about wanting to help and serve women. And for me, personally, really one of the

hardest things is that I receive emails on a regular basis from women who do exist in the shadows, not just other abortion survivors like me but women who had abortions, regret them, and are living in pain.

I have to respond to the emails of women who say, "Melissa, can you help me obtain my medical records from my abortion? Can you help me find out if my child is living still today?" That is an interesting place for someone like me to be in, but that is what I see in my experiences.

Mr. GOHMERT. Well, thank you, and I appreciate your working through that with other individuals.

Ms. Busy Philipps, because you are sitting beside Dr. Phillips, but would you agree that somebody who has survived an abortion like Melisa Ohden has a right, when she is born, to life, to control over her body, where someone else doesn't take her life?

Ms. PHILIPPS. Well, first of all, I want to thank her for sharing her story. I—you know, it is not—although I played a doctor on television, sir, I am actually not a physician. [Laughter.]

Mr. GOHMERT. Right. No, but you have given very compelling testimony and I appreciate it. You have obviously given these issues a lot of thought.

Ms. PHILIPPS. Correct, sir.

Mr. GOHMERT. That is why I was asking you.

Ms. PHILIPPS. Yeah. I think that it is something that is very important. I don't believe that a politician's place is to decide what is best for a woman, and, you know, it is a choice between a woman and her doctor.

I can't—

Mr. GOHMERT. So what about a baby and the doctor? That is my question.

Ms. PHILIPPS. Yes, sir. Well, I, again, I can't speak to her experience because I was not there, and so I do not want to—

Mr. GOHMERT. Okay. Well, I just wondered how far you are feeling about that, because once she is born, would you agree that she is a person in being?

Ms. PHILIPPS. Yeah. See, I am not speaking about birth, sir. I am speaking about—

Mr. GOHMERT. Okay. Well—

Ms. PHILIPPS [continuing]. Abortion.

Mr. GOHMERT. Well, I appreciate that, but the concern here is we have got 21 states that allow the termination, and we have heard the governor here—

Ms. PHILIPPS. Yes, and—

Mr. GOHMERT [continuing]. Just across the river, in Virginia. Thank you. I appreciate it.

Ms. PHILIPPS. No. I just wanted to say, Mr. Gohmert, I appreciate that, what you are trying to get at, and I do—

Mr. GOHMERT. Well, I wasn't trying to get at anything.

Ms. PHILIPPS. No, no, no.

Mr. GOHMERT. You have answered my question. You were sure—so my time, I only have a minute and a half.

I would like to ask, Ms. Bennett, you have obviously done a great deal of study. Have you run into others that you have personally talked to that were in situations like Ms. Ohden?

Ms. BENNETT. I have other friends who have survived an abortion. My friend, Claire Culwell, she survived an abortion. Unfortunately, the reason that she survived was because the abortion took the life of her twin brother, and the doctor, the abortion doctor didn't know that there was twins and so he thought that he had done a successful abortion. And then later on her mother realized that she was still pregnant and Claire was inside of her, because there was twins. And she was adopted, but when she was born she had to be put in a—she was in a body cast and her hip was dislocated, and she suffered greatly because of that.

And there are other abortion survivors. Josiah Presley is another one, and he is missing part of his arm because of the abortion procedure. And like Melissa said, there are others that are in the shadows. It takes a lot of courage to come out and share a story like that. And so there are many more that we—we are not privileged to know their stories.

Mr. GOHMERT. Thank you. And I am being very serious. I appreciate all of you being here because I know what it is to come and testify, and I wish there were a better way to make laws than so-called politicians to come together and enforce their will through the laws. But, unfortunately, it happens every day. I wish it would happen a whole lot less. But I appreciate you all being here and your obvious concern about the issue.

I yield back.

Mr. COHEN. Thank you, sir. I recognize the chair.

Mr. NADLER. Thank you, Mr. Chairman. I ask unanimous consent that this statement from the National Partnership for Women and Families be placed in the record.

Mr. COHEN. Without objection.

[The information follows:]

MR. NADLER FOR THE OFFICIAL RECORD



**House Committee on the Judiciary
Subcommittee on the Constitution, Civil Rights, and Civil
Liberties
Hearing on "Threats to Reproductive Rights in America"**

June 4, 2019

Statement Submitted by
National Partnership for Women & Families
1875 Connecticut Avenue NW
Suite 650
Washington, DC 20009

Dear Chairman Cohen, Ranking Member Johnson and Members of the Subcommittee:

The National Partnership for Women & Families is a nonprofit, nonpartisan organization that has fought for decades to advance the rights and well-being of America's women and families, including the right to access abortion care free of shame, stigma or barriers.

Abortion is an essential part of health care and a basic human right. Nearly one in four women in the United States will have an abortion by age 45.¹ Access to abortion care facilitates people's autonomy, dignity and ability to make decisions about their bodies, their lives and their futures. It also enables people to adequately care for themselves and their families, and to fully contribute to American society. In short, abortion is fundamental to women's equality, and all people deserve access to abortion care and to comprehensive reproductive health care.

Yet across the country, access to abortion is under attack with increasing levels of inflammatory rhetoric and disregard for science and medicine or the realities of people's lives. Bans on abortion are moving with alarming speed in state legislatures.² For example, just since January 2019, bans on abortion after 6 weeks – before most people even know that they are pregnant – have passed in Louisiana, Ohio, Georgia, Kentucky and Mississippi and have passed one chamber in legislatures in South Carolina and Tennessee. A ban on abortion after 8 weeks has passed in Missouri, and the state is currently attempting to revoke the license to provide abortion care from the last remaining Missouri clinic, meaning the state could be the first without an abortion provider since before *Roe v. Wade*. Alabama has passed a law that criminalizes abortion at any stage in pregnancy. Trigger laws, which would automatically criminalize abortion in the event that *Roe v. Wade* is overturned, have recently passed in Arkansas, Kentucky and Tennessee. And bans on a commonly-used second trimester abortion procedure have passed in Indiana and North Dakota and are moving forward in Michigan.

These bans are compounded by other efforts at both the federal and state levels to limit access to abortion care and family planning services, such as this administration's Title X gag rule, state efforts to prohibit Planned Parenthood from receiving reimbursement under state Medicaid programs, and other efforts to limit who can provide abortion care and other reproductive health services.

All of this federal and state level activity is part of a concerted and explicit effort to ban abortion outright. **This hearing is a necessary venue for bringing these unprecedented attacks on access to abortion and reproductive health care to light, and for affirming the right of all people to have access to the care that they need, free of barriers, shame or stigma.**

We commend the Chairman for holding today's hearing and urge the House to take seriously the very real, devastating impacts that restrictions or bans on abortion access have on people's health, well-being, and economic security.

People who are denied access to an abortion have been found to suffer adverse physical and mental health consequences. For example, according to a longitudinal study that is frequently cited in peer-reviewed journals, women denied abortion care are more likely to experience eclampsia, death, and other serious medical complications during the end of

pregnancy, more likely to remain in relationships where interpersonal violence is present, and more likely to suffer anxiety.³ Restrictions and bans on abortion care also fall disproportionately on people of color and exacerbate existing health disparities, including maternal health and maternal mortality disparities.

In addition to health impacts, having access to abortion care also benefits the economic security of individuals and families. Research has shown that women who seek but are denied abortion care are worse off financially and significantly more likely to fall into poverty than women who are able to get the care they need.⁴ People who have an abortion are already disproportionately poor, and lack of access to care only further entrenches their economic insecurity. Additionally, women who are denied an abortion had more than three times greater odds of being unemployed six months later than women who were able to access an abortion;⁵ access to abortion is linked with greater workforce attachment and higher lifetime earnings. In one study, women who were able to have an abortion were six times more likely to have positive life plans – most commonly related to education and employment – and are more likely to achieve them than women denied an abortion.⁶

Access to abortion care also benefits children and families, most directly by allowing people to take on the costs of having children when they are best able or to have the resources necessary to care and provide for the children they already have. Research has found that denying women abortion care has negative developmental and socioeconomic consequences for their existing children.⁷

We urge the House to reject efforts to undermine access to abortion care, and to stand up for the health, security and dignity of America's women and families. Following this hearing, **the House should swiftly pass the Women's Health Protection Act (WHPA), which would protect abortion access across the country. The House should also promptly pass the EACH Woman Act, which, as a complement to WHPA, would ensure abortion access for people no matter their income or how they are insured.**

If you have questions, please contact Jessi Leigh Swenson, director of outreach and engagement for reproductive health and rights, at jswenson@nationalpartnership.org or 202-986-2600.

¹ Guttmacher Institute. (2017, October). *Abortion is a common experience for U.S. women, despite dramatic declines in rates*. [News release]. Retrieved 4 April 2019, from <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates>

² Nash, E., Cappello, O., Naide, S., Mohammed, L., & Ansari-Thomas, Z. (2019, April). *Radical Attempts to Ban Abortion Dominate State Policy Trends in the First Quarter*. Retrieved 4 April 2019 from Guttmacher Institute website: <https://www.guttmacher.org/article/2019/04/radical-attempts-ban-abortion-dominate-state-policy-trends-first-quarter-2019>

³ See Advancing New Standards in Reproductive Health: University of California San Francisco. (2018). *Turnaway Study*. Retrieved 4 April 2019, from <https://www.ansirh.org/research/turnaway-study>

⁴ Foster, D., Roberts, S.C., & Mauldin, J. (2012, October). *Socioeconomic consequences of abortion compared to unwanted birth*. Paper session presented at the American Public Health Association annual meeting, from <https://apha.confex.com/apha/240am/webprogram/Paper263858.html>

⁵ Advancing New Standards in Reproductive Health: University of California San Francisco. (2018, August). *Issue Brief: Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions* (p. 1). Retrieved 4 April 2019, from https://www.ansirh.org/sites/default/files/publicationsfiles/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf

⁶ Upadhyay, U., Biggs, M., & Foster, D. (2015, October). *The effect of abortion on having and achieving aspirational one-year plans* (pp. e9-10). *Boston Medical Center Women's Health*, 15, e9-10, from <https://bmcwomenshealth.biomedcentral.com/track/pdf/10.1186/s12905-015-0250-1>.

⁷ Foster, D., Raifman, S., Gipson, J., Rocca, C., Biggs, M. (2019, February). *Effects of carrying an unwanted pregnancy to term on women's existing children* (p. 183). *Journal of Pediatrics*, 205, 183-189.

Mr. COHEN. I now recognize Professor Raskin for five minutes.

Mr. RASKIN. Mr. Chairman, thank you very much. It is hard for me to believe that this is a congressional hearing in 2019. It feels like a scene out of *The Handmaid's Tale*, what we are witnessing across the country and what we are hearing about today. So, Dr. Robinson, you practice in Alabama; is that right?

Dr. ROBINSON. Yes.

Mr. RASKIN. And Alabama may soon have a law—tell me if I am correct—which would compel a 15-year-old girl who has been raped by her stepfather to bring—to bring the pregnancy to term, and if a doctor honored her wish to have an abortion that doctor would be facing 99 years in prison. Do I understand this law correctly?

Dr. ROBINSON. That is correct. And like I said in my testimony, there is no other of medicine where physicians are being threatened with criminalization like this.

If you were the patient, you would want your physician—you would want to be your physician's number one priority when you are sitting in front of them, and with women this should be the same. We shouldn't have physicians put in a place where they are having to contemplate criminal prosecution versus proceeding doing what is best for their patients.

And if you don't mind, I would like to go back and refer to the question that was asked of Ms. Philipps, because I am a physician.

Mr. RASKIN. Please.

Dr. ROBINSON. And states already have laws in place to protect neonates, but it is very, very important to understand that the scenario that was described is not the situation that we are seeing in abortion care here. I can't imagine any situation where that would happen, and I think it is really, really important that we understand—

Mr. RASKIN. And if it does happen it should be illegal, right, if there are unsanitary conditions.

Dr. ROBINSON. Exactly.

Mr. RASKIN. If the women are not treated properly that is obviously a violation of every regulation and law, and whoever does that should be dealt with accordingly.

Dr. ROBINSON. Exactly, and it is important to keep in mind that the majority of abortions take place early in the first trimester. We are not seeing women having abortions—

Mr. RASKIN. Let me ask you about that.

Dr. ROBINSON [continuing]. In the third trimester.

Mr. RASKIN. Can I ask you about that? I have got a million questions for you, Dr. Robinson.

Dr. ROBINSON. Okay.

Mr. RASKIN. Your story just seems extraordinary to me.

We have heard from our friends across the aisle, and I appreciate the intellectual honesty today. But I want America to hear this. We have heard now that when a sperm unites with an egg that is a human life, and the logic of that is the Alabama law, which is if it was the product of a rape, it was the product of incest, if the woman is in—or girl is in no condition to start a family, to be a mother—still that girl would be forced to go ahead and to have a baby, even if it is week three, week four, because the moment—as I understand my colleagues, and the gentleman from Louisiana, I

think, was very clear about it—when the egg and the sperm unite, that is a life and that is when it kicks in.

Now let me ask you about that. You bring a lot of babies into existence, right? You are in OB-GYN and so you are—what do you think about this claim that it should be a criminal act for someone to terminate a pregnancy at one month, which was clearly protected under Roe v. Wade, it was clearly protected under Planned Parenthood v. Casey, which drew the line at viability outside the womb of the mother?

Dr. ROBINSON. Well, I don't support any legislation that pushes abortion care out of the reach of women. I know, as a physician, that it is a really important that all women have access to the care they need, regardless of the point they are in their pregnancy, and I know that any legislation that takes this out of the hands of physicians and patients puts those women at risk.

Mr. RASKIN. Thank you. Ms. Dalven, let me come to you. So it is very clear that all of this litigation is meant to go up to the Supreme Court, which they have successfully gerrymandered now because of the stonewalling of my constituent, Merrick Garland, who didn't get a Supreme Court confirmation hearing. But they think now they have got the perfect straight flush. They are going to be able to destroy Roe v. Wade and Planned Parenthood v. Casey, and our colleagues across the aisle are cheering them along. Okay.

Now, let us say this were to happen. I want to go back to this very interesting question about sterilization and compulsory abortion. If the choice is not a woman's to decide what happens with her pregnancy, pre-fetal viability, which is the Casey framework—so let us say Roe v. Wade is overturned, Casey is overturned. Could the 30 governments which had compulsory sterilization laws, just in the last century, not even a century ago, could they go back to having a compulsory sterilization law? Could authoritarian, right-wing governments throughout the country go to compulsory abortion laws for populations that they don't like, because it would not be a woman's right to choose? At that point it would just be up to the government to decide what happens in the woman's womb?

Ms. DALVEN. This is a real concern if the court were to say that people do not have the right to control what happens with their own body. Even that is a very frightening prospect and it could lead to the frightening prospects that you describe. But what we also know is that—

Mr. RASKIN. And that is not a crazy hypothetical, right? The majority of the states in the country had compulsory sterilization laws for populations that were deemed unfit by essentially authoritarian governments, and most of them were a lot of them existing in the very states which today are trying to ban the woman's right to choose.

Ms. DALVEN. It is certainly true that this country has a disgraceful history of those types of laws. We see those kinds of—and we see that kind of thing happening today, even today, with the Administration's policy of separating immigrant children from their families, so that is a real part of our history.

Mr. RASKIN. All right. I yield back. Thank you very much.

Mr. COHEN. Thank you, sir.

Mr. Cline, you are recognized for five minutes, our distinguished, young, first-year star.

Mr. CLINE. Thank you, Mr. Chairman. I appreciate the witnesses for being here today. I especially want to thank Ms. Bennett and Ms. Ohden for being here today as well. It is an amazing story for both of you, and it is remarkable that you are able to be here today.

You know, Virginia, the Commonwealth of Virginia, is ground zero right now in the fight over late-term abortions, and while I appreciate the discussions of the chairman about states endeavoring to pass pro-life measures like Mississippi, we only need to look at his own State of New York to see just how extreme these laws have gotten.

The law recently signed into—the bill recently signed into law by Governor Cuomo allows abortion on demand through the moment of birth; it allows non-doctors to perform abortions; could result in forcing health professionals to participate in abortions, even if they object; removes protections for children born alive during abortion attempts but leaves them at the mercy of the abortionist who just minutes earlier was trying to kill them; completely removes unborn children from the criminal code, meaning even those who are victims of violent crimes against pregnant women are unprotected.

In Virginia, my own state, we recently saw similar legislation introduced, and the testimony by the patron, she summarized that the bill would have allowed abortionists to self-certify the necessity of late-term procedures, eliminate informed consent requirements, repeal health and safety standards for abortion facilities, permit late-term abortions to be performed in outpatient facilities, remove ultrasound requirements, and eliminate Virginia's 24-hour waiting period.

In her testimony at the hearing, when she was given the hypothetical of a woman who was about to give birth, that has physical signs she is in labor, would that be a time when she could request an abortion if she were in the middle of labor and dilated? The delegate said, "Mr. Chairman, that would be a decision that the doctor, the physician, and the woman would make at that point," and that her bill would allow that, yes. When she claimed that her bill would have done nothing to change Virginia's late-term abortion law, Politifact rated that false.

We then heard from our own governor who, when discussing that bill, said, on the radio, quote, "If a mother is in labor I can tell you exactly what would happen. The infant would be delivered. The infant would be kept comfortable. The infant would be resuscitated, if that is what the mother and the family desired, and then a discussion would ensue between the physicians and the mother." That is an extreme position.

The 14th Amendment says "nor shall any state deprive a person of life, liberty, or property," to begin, and then it goes on—there is no—the word "abortion" is not found in the 14th Amendment but the word "life" is. And when we talk about protecting life I appreciate the difficult and challenging decisions that were made by the women on the panel, and their testimony is stirring. Two of the women were not talking about the important decisions affecting

their lives. They were talking about their lives, the ability to even be here today, and that is significantly different.

So I ask, Ms. Ohdén, you have made it your life's work to discuss your story. Could you describe more about your efforts and the impact that your life, which could have been cut short, has had on others?

Ms. OHDEN. Thank you so much for all of your words, and for acknowledging, I think, what the white elephant in this room is, right? All of these people here today had a privilege that I was not given, and that is simply the right to be born, and not be born accidentally. And as you can hear in my voice, I get choked up about it. We see this as a political issue, but I have to live with this every single day.

And like so many of you on this panel, yes, I am a mother. My daughters are 11 and almost 5. My oldest daughter was born at the very same hospital where my life was supposed to end, and trust me, I didn't want to do that. I didn't think I could do that. But my children will grow up knowing that they are only alive because an abortion failed to end their mother's life.

That is why I do the work that I do, because I don't get to run away from this. I don't get to pretend like maybe this happens to someone else, that this maybe is an issue that doesn't affect me. And I truly believe that if each and every one of you in this room ever lived in my shoes, you would feel very differently about this issue.

Mr. CLINE. Thank you.

Mr. COHEN. You are welcome, sir.

Ms. Scanlon, you are recognized for five minutes.

Ms. SCANLON. Thank you, Chairman Cohen, for holding this important hearing, you know, especially in light of recent attempts to limit critical reproductive rights for women across America.

You know, as we are hearing, there are a million reasons why someone might choose to continue or end a pregnancy, reasons including the life or health of the mother; whether a fetus has a fatal illness or a severe anomaly; the circumstances of conception, including rape or incest; the mother's socioeconomic status; religious, philosophical beliefs. We have also heard, very eloquently, from some of our witnesses, of difficult situations that have informed their decisions, including, apparently, criminal acts, in some cases.

As someone who has used Planned Parenthood for family planning services, to plan my own family, and has also held the hand of a young woman who chose to terminate her pregnancy after she was raped by a sexual predator 20 years her senior, I support the right of all women to make those choices based upon their own unique circumstances.

I believe we must protect women's rights to have access to a full range of reproductive health care options and the ability to make those decisions in consultation with their medical providers, based upon their own circumstances and their own religious beliefs, not someone else's religious beliefs. I also want to thank the young people who are here today, particularly the young women who are taking a stand to protect those rights.

Now, I am particularly concerned, based upon experience I have had with my clients in the legal services world, about the fact that

a person's ZIP code or their socioeconomic status sometimes determines their ability to access basic medical care. And with that, Ms. Dalven, you have talked about the fact that we shouldn't have a theoretical right to abortions but that women with socioeconomic privilege often have more access to reproductive and abortion health care than others, and women of color or of limited means or in rural America are far more likely to have only a theoretical right to abortion.

Can you speak to that topic and how bills like the Women's Health Protection Act, of which I am a proud co-sponsor, might address that issue of justice with respect to reproductive health care?

Ms. DALVEN. Yes. Thank you for the question. Because of restrictions already in place it is difficult, if not impossible, for many people, particularly low-income people, people of color, immigrants, folks who live in rural America, to get the care they need. And there are—I will just give you an example of three types of laws that contribute to that.

One are laws that prevent insurance coverage from covering abortion care, like the Hyde Amendment, and other State—similar laws. Those laws make it impossible for many people to pay for the care they need. There was a recent study by the Fed that showed that 40 percent of Americans would have real difficulty paying for an unexpected \$400 expense. So you can imagine the difficulty of coming up with the money for an abortion.

The second type of laws are clinic shutdown laws that have left 11 million American women more than an hour's drive from a clinic.

And the third are laws that require people to make multiple unnecessary trips to the clinic before they can get the abortion care they need.

So just imagine that you are a person who has a minimum-wage shift job that doesn't allow you any flexibility to take time off of work, doesn't allow you any paid time off, and you are trying to mount these really insurmountable barriers of trying to get to the clinic, not once, not twice, not around the corner but more than 100 miles away, perhaps without a car, often without public transportation systems. It is really near impossible for people to get the care they need.

We heard Dr. Robinson talk about her patients who have to sleep in the car overnight because they lack the means to stay in a hotel and are forced to go to these unnecessary trips.

So I really thank you for the question because it shows that even if the court doesn't overturn Roe, we have tremendous barriers and we need the Women's Health Protection Act and the Each Women Act to ensure that every person who needs an abortion can get it, no matter where they live and no matter how much money they make.

Ms. SCANLON. And, Dr. Robinson, one quick question for you. There has been some arguments made today that providing abortion care harms women of color and minority populations. Do you have a response to the suggestion that by providing the care that you give you are harming minority communities?

Dr. ROBINSON. I am appalled by any insinuation that refers to the painful history that we, as African Americans, have experi-

enced, the oppression that my people have experienced, to use that as a way to restrict abortion access. I know that all women need access to safe abortion care, women from all backgrounds, and it is very important that we focus on what is most important, and utilizing race as a reason or to point out a reason that we should not have this access is unacceptable.

Ms. SCANLON. Thank you. I yield back.

Mr. COHEN. Ms. Garcia from Houston, Texas, is recognized for five minutes.

Ms. GARCIA. Thank you, Mr. Chairman, and thank you for giving us the opportunity to talk about a very important topic, and perhaps prepare for what may be coming later in the Supreme Court.

Before I begin my question I wanted to introduce someone in the audience, Alicia Hutt, who is here with us today, shadowing me. You know, Congresswoman Bass has a shadow program from her Caucus on Foster Youth, and we are really pleased to have her today. I think she is getting a really good, on-the-ground education. She is a social work student in Texas and I would like to welcome her today.

Secondly, you know, I am 1 of 10 children. I am Catholic but I am pro-choice. I know what my church says but I also know that I cannot impose those religious beliefs on others. So I have been an advocate for a woman's right to choose, which simply does mean that it is up to the woman, her physician, and her network—her husband, her family—to make this decision, and it is not something that a politician should set their will on someone else.

So for me it is troubling to hear some of the remarks that have been made by some of my colleagues and some of the witnesses, particularly when it comes to serving vulnerable populations, underserved populations, and women of color. Because I have seen, firsthand, what it does in terms of negative impact when women of color in underserved communities don't have the proper health care that they need.

And I was really struck by the testimony of Dr. Phillips, when you said that the mortality rate is increasing because we are putting more focus on the fetal well-being than on the mother's well-being.

Could you just—I mean, what does that really mean? I mean, how does it impact Latinas like myself? How does it impact African American women, Native American women, if that focus is shifting?

Dr. PHILLIPS. Thank you for this question. There are many avenues by which we are seeing this play out in the medical field. One is perhaps altruistic, in a sense. Physicians are working to promote fetal well-being by postponing deliveries under circumstances where we realize that continuing the pregnancy for even a day or a week may increase that patient's risk of acute issues, including mortality, and now long-term health care risks. They may be doing this because they are hoping for the best and thinking that they can postpone delivery until the fetus is a little bit farther along.

But there are many examples of communities where the doctors themselves have different approaches and are postponing care for the patient, who is in front of them, the person who is front of them with the idea that they are instead promoting fetal well-

being. And one way to understand this is to understand the ethical principles that all physicians are guided by. The individual in front of us is our patient, but she is also the person. That is the definition. The fetus is a patient but does not have the personal rights that supersede the woman's. And this plays out all the time care.

Ms. GARCIA. And, in fact, we have one of the highest mortality rates in this country.

Dr. PHILLIPS. Right. Right.

Ms. GARCIA. Higher than some other Third World countries.

Dr. PHILLIPS. Correct, and a lot of research into this, and questioning into this, may very well be that either the health care systems or the doctors themselves or opinions of physicians themselves may be pushing the limits—

Ms. GARCIA. Thank you.

Dr. PHILLIPS [continuing]. Of maternal health and care.

Ms. GARCIA. Thank you. I need to get one more in, and this one is for Ms. Dalven.

You also have had a case that involved the Trump administration's, in my mind, blatant abuse of constitutional law by trying to block abortion access to immigrant woman. What is the status of that case and where might we be going in the future?

Ms. DALVEN. Thank you for your question. This was a case, we call it the Jane Doe case. Jane Doe was a young woman who came to this country without her parents, seeking a better life for herself. She was put into a government-run shelter and found out she was pregnant and requested an abortion, and the Trump administration did everything they could to block her, took every single step they could. They sent her to an anti-abortion counseling center, they told her abusive parents, and then they simply blocked the doors.

So we went to court on her behalf. She was resolute in her decision, and after four weeks of unconstitutional delay Ms. Doe was able to finally get her abortion.

That did not stop the Trump administration. We had to go to court on behalf of young woman, after young woman, after young woman, until we finally got the court to say that we could—that the Administration couldn't enforce this policy against any pregnant person.

The Trump administration did not stop. They have appealed that decision and we are waiting for a decision from the Court of Appeals.

Ms. GARCIA. Thank you. I yield back.

Mr. COHEN. Thank you, Ms. Garcia, and like Ms. Garcia, and like Archie Bell and the Dreells, from Houston, Texas, Sheila Jackson Lee.

Ms. JACKSON LEE. Mr. Chairman, thank you, and how important this hearing is to all of the witnesses. Whether agree with your positions or not, this is a crucial human rights question. This is a question of dignity and respect. I take great issue to the fact that anyone who believes in choice, which is far different from flag waivers for abortion, which is how the anti-abortion people try to portray us, and we are not. And I refuse to accept that definition because we are a multi-conglomerate of individuals of faith and other perspectives. We are women and we are men, and we are

Americans. And my heart broke with the series of outrageous, despotic legislative acts from pompous, self-righteous men who had the audacity, and it might have been men and women, who had the audacity to take away the liberty of anyone.

Let me say that I believe that in the course of Supreme Court cases and others, the dignity of the unborn is respected. I have been through a lot, partial birth abortion and others, which is not a free-for-all. It is a medical decision being made by a doctor, the faith of the individual and family.

Let me quickly ask these questions so my time does not run out, but I want to be very clear that I take great issue with definitions that are not me. What is a definition of myself is the fact that I lived through the era of coat hangers, brokenhearted lives, and death, bleeding to death, backroom operating tables or back alleys, or young people being in your church and all of a sudden you didn't know where they were. God forbid they had died or they were sent somewhere to have that baby. Is that the life that we want for a free and equal country?

Let me, Ms. Murray, I have great respect for your family, the Hill family, and, of course, Professor Hill. The late Professor Hill himself was a great humanitarian, lost his life shortly after returning from South Africa on the question of climate. What a visionary. Thank you for being here, and thank you for your work. I want you to answer that question of this whole Fourteenth Amendment and the dastardly series of legislative initiatives, and particularly in Alabama, which is absolutely appalling. If you would hold your point, I just want to get all my questions out and be fair to the chairman to make sure that I have all of them.

Let me just say to the ACLU, that case was in our district. We are honored by the fact that you never stopped, that young lady. I may be able to ask you a question, but I am going to just thank you for your work.

Dr. Robinson, you lived it. You are from Huntsville, and I happen to have been on the board of Oakwood College. You are from Huntsville. I couldn't imagine the picture of those who voted for it, but from a health perspective, how devastating is it to women's health? How many lives are we going to lose if we continue in this ridiculous pathway? And let me go to Ms. Dalven, as well. Is it true that States placing such restrictions on reproductive care under the guise of ensuring the health of these constituents is, in fact, deficient of evidence? And you state that in Alabama, two-thirds of the counties do not have a hospital that offer obstetrical care and has the highest infant mortality rate. So for those who love life, how devastating it is to not have this in Alabama, and then look what they do. How outrageous.

So three people I have given a question. Professor Murray, thank you. Welcome.

Ms. MURRAY. Thank you, Representative Lee. Thank you for remembering my father-in-law, Dr. Hill, who was indeed a great man, a greater Houstonian. Let me first start with your point about the Fourteenth Amendment. You are absolutely right that the recent laws enacted in Alabama and Georgia flagrantly flout the precedents of this Court. They are patently unconstitutional.

We only need the Supreme Court to follow exigent precedent to discover that.

I also wanted to point out that Representative Cline noted that the right to abortion is not included in the Constitution. I will only note that there are other rights that are not included explicitly in the Constitution, like the right to marry, the right to raise children in the manner of your choosing, the right to travel, and, more recently, the concept of executive privilege that we have heard quite a bit about. None of these are explicitly enumerated in the Constitution. Thank you.

Ms. JACKSON LEE. Thank you. Dr. Robinson? I think that is Dr. Robinson? You heard my question to you?

Dr. ROBINSON. Could you repeat it, please?

Ms. JACKSON LEE. Well, I asked you about the problem, you having experienced it, but the problem of the particular law in Alabama as it impacts on having children or not.

Dr. ROBINSON. Yes, I am experiencing that. I am an obstetrician/gynecologist, and I am already seeing the impacts of people having opposition to abortion care, and like we talked about earlier, focusing more on the fetus and not the mother. As an obstetrician, I have two scenarios that I can explain to you very quickly just so you understand how this impacts patients.

One young lady with severe preeclampsia, which, if she was not delivered, she continues to get worse, and it could cause her to die or either severely harm her health over the long term. I had difficulty getting the approvals I needed to deliver that young lady in the hospital. And also with a mother who was pregnant with twins. She delivered very early. She was only 20 weeks, and after one fetus passed, she was bleeding very briskly in the room. However, we did not want to do a Cesarean section because that would be an unnecessary procedure for that mother. I asked a nurse to go ahead and start her Pitocin just to make her start to contract so that the other fetus could pass to decrease her hemorrhaging. And even in that case, after I had left the room and I came back and asked had the orders that I had given, have they been implemented, I was told that they had not because one fetus, the fetus that was still remaining inside, had cardiac activity or still had a heartbeat. Either way it goes, this mother, she was bleeding. She was very pre-term, and that fetus was going to be expelled. The water had already broken.

And I appreciate the scenarios or the situations that these young ladies shared, but I would like you to know that those are criminal acts, and we already have laws against that. So that is not what abortion providers are doing here. Generally when there is a pregnancy that we induce in the third trimester, it is for fetal indications. And in that case, those fetuses are not going to live outside of the womb. They have medical diagnoses that will prevent that. And when you propose a scenario when you have a fetus born live in a clinic, you ask would we render any care, like I said, we have laws that already protect neonates, but this is not happening in abortion clinics in Alabama.

But I would tell you, if it ever did happen, I would say we should transfer those babies, but that does not happen. And for those that

are born because of fetal anomalies, they can't live outside of the womb.

Ms. JACKSON LEE. Thank you.

Dr. ROBINSON. So I would be against implementing any heroic measures in transferring to the hospital.

Ms. JACKSON LEE. Thank you.

Dr. ROBINSON. It would be a waste of resources.

Ms. JACKSON LEE. Thank you. May I get Ms. Dalven to—thank you so very much. I am sorry.

Mr. COHEN. Thank you. We are out of time.

Ms. JACKSON LEE. Well, could she just answer the maternal mortality? She was my third person.

Mr. JOHNSON of Louisiana. Mr. Chairman, if we allow that, could I have 1 additional minute, and we could all be fair?

Ms. JACKSON LEE. Well—

Mr. COHEN. That is why we are not going to allow it. [Laughter.]

Ms. JACKSON LEE. If you could give it to me in writing, Ms. Dalven.

Thank you so very much.

Mr. COHEN. Thank you very much. We have had an excellent hearing. I would want to have one more question, and that is, Ms. Gray, you have been an excellent witness. You are the youngest of the panel, and oftentimes the youngest gets overlooked. A long time ago I was the youngest, and I would just like to ask you if you have anything you would like to express to us about your experience, either in this particular area or just about being here in Congress and what you thought of this panel, and what you think we should do better.

Ms. GRAY. Thank you for asking me. I am very happy to be here and seeing all sides of this debate. The thing that I want us to leave with is that the barriers I personally faced and many people face in accessing abortion, it is really just another step to criminalizing poor people. And in doing that, we are making it harder for people to have families. We are making it harder for people to decide that they can't afford to have families. We are making it harder for people like my father to be able to get homes, and people like my mother to be able to be rehabbed and have normal, successful lives.

Another thing that I would like for us to leave with is that whether we all know it, we know someone who has an abortion. We know someone who has been impacted by these laws, and it is unfair for us to pass our judgment, especially when we are passing judgment on people who want and need our support. I want to thank you for having me here, and I want everyone to know that everyone loves someone who has had an abortion. Thank you.

Mr. COHEN. Thank you, and I want to thank you and everybody else on our panel for being here. We have had a great, great panel. Thank you all.

Without objection, all members will have 5 legislative days to submit additional written questions for the witnesses or any additional materials for the record.

With that, the hearing is adjourned.

[Whereupon, at 12:18 p.m., the subcommittee was adjourned.]

APPENDIX

Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities

APRIL 2018

Black women in the United States experience unacceptably poor maternal health outcomes, including disproportionately high rates of death related to pregnancy or childbirth. Both societal and health system factors contribute to high rates of poor health outcomes and maternal mortality for Black women, who are more likely to experience barriers to obtaining quality care and often face racial discrimination throughout their lives.

Due to racism, sexism and other systemic barriers that have contributed to income inequality, Black women are typically paid just 63 cents for every dollar paid to white, non-Hispanic men. Median wages for Black women in the United States are \$36,227 per year, which is \$21,698 less than the median wages for white, non-Hispanic men.¹ These lost wages mean Black women and their families have less money to support themselves and their families, and may have to choose between essential resources like housing, childcare, food and health care.

These trade-offs are evident in Black women's health outcomes and use of medical care. Compared to white women, Black women are more likely to be uninsured,² face greater financial barriers to care when they need it³ and are less likely to access prenatal care.⁴ Indeed, Black women experience higher rates of many preventable diseases and chronic health conditions including higher rates of diabetes, hypertension and cardiovascular disease.⁵ When, or if, Black women choose to become pregnant, these health conditions influence both maternal and infant health outcomes.



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To improve Black women's maternal health, we need a multi-faceted approach that addresses Black women's health across the lifespan, improves access to quality care, addresses social determinants of health and provides greater economic security.

Background: Black maternal health disparities

Too many Black women are dying in pregnancy and childbirth. Black women in the United States are more likely to die from pregnancy or childbirth than women in any other race group.⁶

- ▶ Black women are three to four times more likely to experience a pregnancy-related death than white women.⁷
- ▶ Black women are more likely to experience preventable maternal death compared with white women.⁸
- ▶ Black women's heightened risk of pregnancy-related death spans income and education levels.⁹

Black women experience more maternal health complications than white women. Black women are more likely to experience complications throughout the course of their pregnancies than white women.

- ▶ Black women are three times more likely to have fibroids (benign tumors that grow in the uterus and can cause postpartum hemorrhaging) than white women, and the fibroids occur at younger ages and grow more quickly for Black women.¹⁰
- ▶ Black women display signs of preeclampsia earlier in pregnancy than white women. This condition, which involves high blood pressure during pregnancy, can lead to severe complications including death if improperly treated.¹¹
- ▶ Black women experience physical "weathering," meaning their bodies age faster than white women's due to exposure to chronic stress linked to socioeconomic disadvantage and discrimination over the life course, thus making pregnancy riskier at an earlier age.¹²

Black-serving hospitals provide lower quality maternity care. Seventy-five percent of Black women give birth at hospitals that serve predominantly Black populations.¹³

- ▶ Black-serving hospitals have higher rates of maternal complications than other hospitals. They also perform worse on 12 of 15 birth outcomes, including elective deliveries, non-elective cesarean births and maternal mortality.¹⁴

Many Black women have a difficult time accessing the reproductive health care that meets their needs. Access to reproductive health care, which helps women plan their families, improves health outcomes for women and children.

- ▶ Black women experience higher rates of unintended pregnancies than all other racial groups,¹⁵ in part because of disparities in access to quality contraceptive care and counseling.¹⁶
- ▶ Many Black women lack access to quality contraceptive care and counseling.¹⁷ For example, in a recent analysis of California women enrolled in Medicaid, Black women were less likely than white or Latina women to receive postpartum contraception, and when they did receive it, they were less likely to receive a highly effective method.¹⁸
- ▶ Black women's access to abortion is limited,¹⁹ and they may be more likely to experience the ill effects of abortion restrictions – such as delayed care, increased costs or lack of access to care.²⁰

Policymakers, health care professionals and communities can improve Black women's maternal health.

Expand and maintain access to health coverage.

Only 87 percent of Black women of reproductive age have health insurance, and many more experience gaps in coverage during their lives. To improve Black women's health outcomes, policies should focus on expanding and maintaining access to care and coverage.

Women need health coverage throughout their lifespan including access to preventive health care, such as birth control, to maintain their health and to choose when and whether to become a parent. For women who choose to become a parent or expand their families, good prenatal and maternity care are critically important for healthy pregnancies and healthy children. Pregnant women who lack insurance coverage often delay or forgo prenatal care in the first trimester,²¹ and inadequate prenatal care is associated with higher rates of maternal mortality.²²

Black women are more likely to live in the South, where women generally experience poorer health outcomes and where many states have chosen not to expand Medicaid coverage,²³ which leaves many Black women in the "coverage gap." Women fall into the coverage gap because they earn too much to qualify for traditional Medicaid, but not enough to purchase insurance on the Affordable Care Act (ACA) marketplace; as a result, they lack access to health coverage. Expanding Medicaid coverage would improve maternal outcomes for Black women by providing better access to care and reducing financial instability.

Provide patient-centered care that is responsive to the needs of Black women.

Black women should receive health care that is respectful, culturally competent, safe and of the highest quality. Unfortunately, research shows that Black women receive a lower quality of care than white women.²⁴ Much too often, Black women are subject to discrimination in the health care field – 22 percent report discrimination when going to the doctor or clinic.²⁵

Public policies and medical practice should incentivize providing patient-centered care that focuses on Black women's individualized needs, including non-clinical, social needs. Moreover, policies should endeavor to eradicate cultural biases and discrimination in medical practice and medical education, increase provider diversity in maternity care and hold individual providers and hospital systems accountable if they fail to provide unbiased, high-quality, evidence-based care.

Address the social determinants of health.

Social determinants of health are the conditions under which people live, work and play. Social determinants have consequential and varying effects on health outcomes across race and ethnicities. For Black women who are affected by structural inequality and discrimination, the chronic stress of poverty and racism has been shown to have a deleterious effect on health outcomes and is linked to their persistent maternal health disparities.²⁶

To improve Black maternal health outcomes, social determinants of health must be addressed through policies that raise incomes and build wealth; provide access to clean, safe and affordable housing; improve the quality of education; prioritize reliable public transportation and transport for medical appointments; and increase the availability of healthy, affordable food.

Expand paid family and medical leave.

Black women need paid leave to take care of their own health needs and to have time to care for their children. More than one in four Black workers report that there was a time in the last two years that they needed or wanted to take time away from work for parental, family or medical reasons but could not.²⁷ Only 30 percent of Black mothers are both eligible for and able to afford to take unpaid leave under the federal Family and Medical Leave Act.²⁸

Only 15 percent of all workers have access to paid family leave through their employers. Paid family and medical leave allows workers to earn a portion of their pay while taking time off from work to care for themselves or their families. But current inadequate leave policies mean that Black mothers are more likely to quit and/or be fired from their jobs after giving birth than white women,²⁹ or return to work before they are healthy enough to do so. Lawmakers should pursue robust, comprehensive paid leave policies that are accessible and affordable for all working people.

Expand access to quality, patient-centered and comprehensive reproductive health care.

Quality, patient-centered reproductive health care is critical to improving maternal health and addressing the reproductive health disparities that Black women face including higher rates of unintended pregnancies and restricted access to abortion. Researchers attribute these disparities to a number of factors, including disparities in access to high-quality health care generally, and family planning services specifically.³⁰ Indeed, women with unintended pregnancies are at increased risk for maternal mortality and morbidity, maternal depression, experiencing physical violence during pregnancy,³¹ infant mortality, birth defects, low birth weight and preterm birth.³²

Black women also live with a legacy of reproductive oppression, and continue to experience reproductive coercion, sometimes leading to a distrust of the health care system that further exacerbates disparities. For instance, Black women are more likely to report having been pressured by a clinician to use a contraceptive method.³³ Moreover, some Black women may be forced to continue pregnancies because onerous restrictions and a lack of insurance coverage have pushed abortion out of reach.

This experience falls short of the level of high-quality, patient-centered care that all women should be able to expect. Policymakers must work to ensure that Black women are able to plan their families in the way that feels best for them, which includes access to counseling on the contraception method of their choice, access to abortion care without restrictions and access to prenatal and maternity care from providers they trust.

Expand and protect access to trusted community providers.

Community health care providers play an essential role in providing Black women with basic, reproductive and maternal health care services. Without these vital resources, many Black women would not have information about or access to birth control, annual exams, Pap tests and other essential preventive care.³⁴ Policymakers should expand funding for trusted, community-based providers including Planned Parenthood. Community-based providers can help Black women get and stay healthy throughout their lifespan, including when, or if, they choose to become a parent.

Expand protections for pregnant workers.

Women report pregnancy discrimination across races and ethnicities, but Black women are disproportionately affected. Nearly three in 10 charges of pregnancy discrimination (28.6 percent)

were filed by Black women from 2011-2015, yet Black women comprise only 14 percent of women ages 16 to 54 in the workforce.³⁵ Pregnancy discrimination has serious consequences for women and their families. Women who are demoted, not promoted or discharged because they are, or might become, pregnant can lose critical income.³⁶ If they are discharged or have their hours cut, they may lose their health insurance and other workplace supports at a time when their families' budgets are already stretched. Because Black women are also at a higher risk for pregnancy-related complications like preterm labor, preeclampsia and hypertensive disorders,³⁷ the loss of wages and health insurance due to pregnancy discrimination is especially challenging.

Stronger protections for pregnant workers, including federal and state laws that ensure that employers provide reasonable accommodations to pregnant women, robust enforcement of the Pregnancy Discrimination Act and continued education about existing legal rights are critical to combatting and, ultimately, eliminating pregnancy discrimination in this country.

Invest in health care safety and quality improvement initiatives.

Maternal mortality is three to four times higher for Black women than it is for white women, and Black women are more likely to experience complications during pregnancy and childbirth. There are existing, proven safety and quality improvement initiatives that need greater uptake to meaningfully improve health care outcomes for Black women.

Maternal mortality review committees increase understanding of the underlying and contributing causes of pregnancy-related deaths and the reasons maternal mortality affects Black women at such a high rate. A structured death review process can provide powerful data and information to facilitate change that improves the health of women before, during and after pregnancy.³⁸ Review committees should include medical professionals, community stakeholders, health advocates, patients and family members. Together, they should work to identify factors that lead to complications and corresponding strategies to avoid preventable complications as well as provide recommendations aimed at reducing pregnancy-related deaths.

Hospitals and medical practices should be encouraged and supported in participating in quality improvement efforts that are known to improve maternal health. For example, the Alliance for Innovation on Maternal Health (AIM) is a national data-driven maternal safety and quality improvement initiative based on proven implementation approaches to improving maternal safety and outcomes in the United States.³⁹

Similarly, the California Maternal Quality Care Collaborative provides a multifaceted, solutions-based approach to quality improvement including toolkits on how to address the leading causes of preventable death and complications for mothers and infants.⁴⁰ State-level perinatal quality collaboratives have begun to address severe maternal morbidity and related quality and safety issues and should be encouraged to expand this critical work as they can scale implementation of the AIM resources and toolkits across states.⁴¹

Many structural and societal issues affect Black women's health. There is extensive research and evidence that point the way to strategies to improve our health care system and ensure that it delivers safe, effective and evidence-based maternal health care to everyone.

Conclusion

Black women deserve to have safe and healthy pregnancies and childbirth. To meaningfully improve Black maternal health outcomes, we need systemic change that starts with the health care system, improves access to care and makes the places Black women live and work healthier, more fair and more responsive to their needs. Only when we do that will Black women be able to achieve their optimal health and well-being throughout their lifespan, including if they choose to become parents.

Endnotes

¹ National Partnership for Women & Families. (2017, September). *Quantifying America's Gender Wage Gap by Race*. Retrieved 4 April 2018, from <http://www.nationalpartnership.org/research-library/workplace-fairness/fair-pay/quantifying-americas-gender-wage-gap.pdf>

² National Partnership for Women & Families. (2017, October). *Women's Health Coverage: Sources and Rates of Insurance*. Retrieved 4 April 2018, from <http://www.nationalpartnership.org/research-library/health-care/womens-health-coverage-sources-and-rates-of-insurance.pdf>

³ The Commonwealth Fund. (2017, February). *Biennial Health Insurance Survey, 2003-2016*. Retrieved 4 April 2018, from <http://www.commonwealthfund.org/interactives-and-data/surveys/biennial-health-insurance-surveys/2017/biennial-explorer>

⁴ Agency for Healthcare Research and Quality. (2012, October). *Disparities in Health Care Quality Among Minority Women Selected Findings From the 2011 National Healthcare Quality and Disparities Reports*. U.S. Department of Health and Human Services. Retrieved 4 April 2018, from <https://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr11/minority-women.html#maternal>

⁵ Office of Minority Health. (2017, May). *Profile: Black/African Americans*. Retrieved on October 30, 2017, from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19>

⁶ Tucker, M. J., Berg, C. J., Callaghan, W. M., & Hsia, J. (2007). The Black-White disparity in pregnancy-related mortality from 5 conditions: differences in prevalence and case-fatality rates. *American Journal of Public Health*, 97(2), 247-251. Retrieved 4 April 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/?term=Tucker+MJ%2C+Berg+CJ%2C+Callaghan+WM%2C+Hsia+J>

⁷ Creanga, A. A., Syverson, C., Seek, K., & Callaghan, W. M. (2017). Pregnancy-Related Mortality in the United States, 2011-2013. *Obstetrics & Gynecology*, 130(2), 366-373. Retrieved 4 April 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/28697109>

⁸ Louis, J. M., Menard, M. K., & Gee, R. E. (2015). Racial and ethnic disparities in maternal morbidity and mortality. *Obstetrics & Gynecology*, 125(3), 690-694.

⁹ Black Mamas Matter Alliance & Center for Reproductive Rights. (2016). *Research Overview of Maternal Mortality and Morbidity in the United States*. Retrieved 2 April 2018, from https://www.reproductiverights.org/sites/crr.civicsactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf

¹⁰ Eltoukhi, H. M., Modi, M. N., Weston, M., Armstrong, A. Y., & Stewart, E. A. (2014). The health disparities of uterine fibroid tumors for African American women: a public health issue. *American Journal of Obstetrics & Gynecology*, 210(3), 194-199. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3874080/>

¹¹ Shahul, S., Tung, A., Minhai, M., Nizamuddin, J., Wenger, J., Mahmood, E., & Talmor, D. (2015). Racial disparities in comorbidities, complications, and maternal and fetal outcomes in women with preeclampsia/eclampsia. *Hypertension in Pregnancy*, 34(4), 506-515. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4782921/>

¹² Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: evidence and speculations. *Ethnicity & Disease*, 2(3), 207-221.

¹³ Howell, E. A., Egorova, N., Balbierz, A., Zeitlin, J., & Hebert, P. L. (2016). Black-white differences in severe maternal morbidity and site of care. *American Journal of Obstetrics & Gynecology*, 214(1), 122-e1. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pubmed/26283457>

¹⁴ Creanga, A. A., Bateman, B. T., Mhyre, J. M., Kuklina, E., Shilkret, A., & Callaghan, W. M. (2014). Performance of racial and ethnic minority-serving hospitals on delivery-related indicators. *American Journal of Obstetrics & Gynecology*, 217(6), 647-e1. Retrieved 30 March 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4290934/>

¹⁵ Finer, L. B. & Zolna, M. R. (2011). Unintended pregnancy in the United States: Incidence and disparities, 2006 (p. 480). *Contraception*, 84, 478-485.

¹⁶ See, e.g., Dehlendorf, C., Park, S. Y., Emeremni, C. A., Comer, D., Vincett, K., & Borrero, S. (2014). Racial/ethnic disparities in contraceptive use: Variation by age and women's reproductive experiences (p. 526.e1). *American Journal of Obstetrics & Gynecology*, 210(6), 526.e1-526.e9.

¹⁷ Ibid.

¹⁸ deBocanegra, H. T., Braughton, M., Bradberry, M., Howell, M., Logan, J., & Shwarz, E.B. (2017). Racial and ethnic disparities in postpartum care and contraception in California's Medicaid program (pp. e3-e4). *American Journal of Obstetrics & Gynecology*, 217(47), e1-e7.

¹⁹ See note 15; see, e.g., Dehlendorf, C., Harris, L. H., & Weitz, T. A. (2013). Disparities in abortion rates: A public health approach. *American Journal of Public Health*, 103(10), 1772-1779.

²⁰ See, e.g., Dehlendorf, C., Harris, L. H., & Weitz, T. A. (2013). Disparities in abortion rates: A public health approach (p. 1776). *American Journal of Public Health*, 103(10), 1772–1779 (describing that “studies have found that restricted access to abortion services can limit women’s ability to abort a pregnancy when they wish to do so, and that these effects may be particularly pronounced for Black women and women with lower educational attainment”); Henshaw, S. K., Joyce, T. J., Dennis, A., Finer, L. B., & Blanchard, K. (2009). *Restrictions on Medicaid funding for abortions: A literature review*. Guttmacher Institute. Retrieved 27 March 2018, from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.295.8439&rep=rep1&type=pdf>

²¹ Egerter, S., Braveman, P., & Marchi, K. (2002). Timing of insurance coverage and use of prenatal care among low-income women. *American Journal of Public Health*, 92(3), 423–427. Retrieved 27 March 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447093/>

²² U.S. Centers for Disease Control and Prevention. *Prenatal Care*. Retrieved 4 April 2018, from <https://www.cdc.gov/healthcommunication/tooltemplates/entertainment/tips/PregnancyPrenatalCare.html>

²³ America’s Health Rankings. (2018). *2018 Health of Women and Children Report*. Retrieved 4 April 2018, from <https://www.americashealthrankings.org/explore/2018-health-of-women-and-children-report>

²⁴ See note 9.

²⁵ Robert Wood Johnson Foundation. (2017, December). *Discrimination in America: Experiences and Views of American Women*. Retrieved 4 April 2018, from https://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2017/rwjf441994

²⁶ Prather, C., Fuller, T. R., Marshall, K. J., & Jeffries IV, W. L. (2016). The impact of racism on the sexual and reproductive health of African American women. *Journal of Women’s Health*, 25(7), 664–671. Retrieved 4 April 2018, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939479/>

²⁷ Horowitz, J. M., Parker, K., Graf, N., & Livingston, G. (2017, March 23). *Americans Widely Support Paid Family and Medical Leave, but Differ Over Specific Policies*. Pew Research Center. Retrieved 18 March 2018, from <http://www.pewsocialtrends.org/2017/03/23/americans-widely-support-paid-family-and-medical-leave-but-differ-over-specific-policies/>

²⁸ diversitydatakids.org. (2015). *Policy Rankings: The Family and Medical Leave Act*. Brandeis University, The Heller School, Institute for Child, Youth and Family Policy Publication. Retrieved 18 March 2018, from <http://www.diversitydatakids.org/data/ranking>

²⁹ Laughlin, L. (2011, October). *Maternity Leave and Employment Patterns of First-Time Mothers: 1961–2008*. U.S. Census Bureau Publication. Retrieved 28 March 2018, from <http://www.census.gov/prod/2011pubs/p70-128.pdf>

³⁰ See note 15; see note 20, Henshaw; see, e.g., Dehlendorf, C., Park, S. Y., Emeremni, C. A., Comer, D., Vincett, K., & Borrero, S. (2014). Racial/ethnic disparities in contraceptive use: Variation by age and women’s reproductive experiences (pp. 526–e7). *American Journal of Obstetrics & Gynecology*, 210(6), 526.e1–526.e9 (citations omitted). A number of studies have demonstrated that there is not a significant disparity in knowledge about contraception between Black women and white women. See, e.g., Craig, A. D., Dehlendorf, C., Borrero, S., Harper, C. C., & Rocca, C. H. (2014). Exploring young adults’ contraceptive knowledge and attitudes: Disparities by race/ethnicity and age. *Women’s Health Issues*, 24(3), e281–e289; Rocca, C. H. & Harper, C. C. (2012). Do racial and ethnic differences in contraceptive attitudes and knowledge explain disparities in method use? Perspectives on Sexual and Reproductive Health, 44(3), 150–158. See also, e.g., Dehlendorf, C., Harris, L. H., & Weitz, T. A. (2013). Disparities in abortion rates: A public health approach (p. 1776). *American Journal of Public Health*, 103(10), 1772–1779.

³¹ See, e.g., generally Tsui, A. O., McDonald-Mosley, R., & Burke, A. E. (2010). Family planning and the burden of unintended pregnancies. *Epidemiologic Reviews*, 32, 152–174.

³² See, e.g., generally Conde-Aguedelo, A., Rosas-Bermúdez, A., & Kafury-Goeta, A. C. (2006). Birth spacing and risk of adverse perinatal outcomes: A meta-analysis. *JAMA*, 295(15), 1809–1823.

³³ Becker, D. & Tsui, A. O. (2008). Reproductive health service preferences and perceptions of quality among low-income women: Racial, ethnic and language group differences (p. 208). *Perspectives on Sexual and Reproductive Health*, 40(4), 202–211.

³⁴ See, e.g., Stevenson, A. J., Flores-Vazquez, I. M., Allgeyer, R. L., Schenckan, P., & Potter, J. E. (2016). Effect of removal of Planned Parenthood from the Texas Women’s Health Program. *New England Journal of Medicine*, 374, 853–860 (describing the negative impact of cuts to family-planning services on women’s access to contraception). Recent studies have also shown that, in Texas, deep funding cuts to family planning services correlated with dramatic increases in the maternal mortality rate. See generally MacDorman, M. F., Declercq, E., & Thoma, M. E. (2018). Trends in Texas maternal mortality by maternal age, race/ethnicity, and cause of death, 2006–2015. *Birth*, 1–9; MacDorman, M. F., Declercq, E., Cabral, H., & Morton, C. (2016). Is the United States maternal mortality rate increasing? Disentangling trends from measurement issues. *Obstetrics & Gynecology*, 128(3), 447–455 (describing how the reported maternal mortality rate in Texas doubled within a two-year period); see also Bassett, L. (2016, August 18). Pregnancy-Related Deaths Nearly Doubled in Texas After Cuts to Women’s Health. *Huffington Post*. Retrieved 27 March 2018, from https://www.huffingtonpost.com/entry/womens-health-texas_us_57b5d949e4b034dc73260bf3

³⁵ National Partnership for Women & Families. (October 2016). *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace*. Retrieved 6 April 2018 from <http://www.nationalpartnership.org/research-library/workplace-fairness/pregnancy-discrimination/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf>

³⁶ Ibid.

³⁷ See note 14.

³⁸ Association of Maternal & Child Health Programs. (n.d.). *MMR Resource Portal for States: Building Capacity for Maternal Mortality Review*. Retrieved 4 April 2018, from <http://www.amchp.org/programsandtopics/womens-health/Focus%20Areas/MMR/Pages/default.aspx>

³⁹ Council on Patient Safety in Women's Health Care. (n.d.). *Alliance for Innovation on Maternal Health*. Retrieved 5 April 5 2018, from <http://safehealthcareforeverywoman.org/aim-program/>

⁴⁰ California Maternal Quality Care Collaborative. (n.d.). *QI Initiatives*. Retrieved 4 April 2018, from <https://www.cmqcc.org/qi-initiatives>

⁴¹ U.S. Centers for Disease Control and Prevention. (2018, January 25). *Perinatal Quality Collaborative*. Retrieved 4 April 2018, from <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm#success>

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at NationalPartnership.org.

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Fighting Back Against Lies and Misinformation About Abortion Care

MAY 2019

Anti-abortion politicians are engaging in a dangerous effort to mislead and confuse the public about abortion care. They are peddling lies about abortion later in pregnancy in order to push their extreme agenda to ban abortion outright. Lawmakers and advocates are standing on solid ground when pushing back on this misinformation. Below are some ways to respond with the facts using an authentic and values-driven voice.

Punch Back with Facts (adapted from Planned Parenthood's [Messaging Guidance](#))

- These claims about abortion later in pregnancy are not true. This is a manufactured controversy.
- Abortion care later in pregnancy is rare. According to the Center for Disease Control, 99% of abortions occur before 21 weeks.
- An abortion that happens later in pregnancy is because of very challenging circumstances, such as when something in the pregnancy has gone very wrong and a woman's life or health is in danger or the fetus will not survive.
- Women and families in these situations face devastating decisions. They deserve our compassion and support — not our judgment and certainly not politicians telling them what to do.

Put Them On Their Heels

You have strong ground to stand on. You work every day to advance policies that make progress for women and families in real ways, you don't just pay it lip service. Call out their hypocrisy with your dedication to real policies that would make change and allow families to thrive. Express your indignation that anti-abortion politicians oppose the very policies that would enable people to have healthy pregnancies and support their families.

They are using lies to manipulate and mislead the public about abortion care. They are simply paving the way for their real goal — banning abortion outright.

- Across the country, access to abortion is under attack with increasing levels of inflammatory rhetoric and disregard for science, medicine or the realities of people's lives. An outrageous ban on abortion after only 6 weeks — before most people even know they are pregnant — has passed in four states. A bill was just passed by the Alabama Legislature that would criminalize abortion at any stage in pregnancy. A bill in Texas would have made it possible to impose the death penalty for women who seek abortion care.
- These bans are compounded by other efforts to cut off access to abortion care and family planning services, such as this administration's Title X gag rule, efforts to defund Planned Parenthood and the administration's rollback of contraceptive coverage.

If they care about healthy pregnancies and healthy babies then they should work to address the fact that the United States has the highest maternal mortality rate in the developed/westernized world, and that Black women are three to four times more likely to die in childbirth than white women.

- Highlight your support the MOMMA's Act, the MOMS Act, the MOMMIES Act and the Quality Care for Moms and Babies Act. All of these bills are focused on eliminating maternal health disparities and improving maternal health by expanding access to postpartum Medicaid coverage, funding maternal mortality review committees, adopting best practices and developing better quality standards.

The very same people peddling lies and purporting to care about pregnant women are the ones who would strip maternity care from health care coverage by undoing Affordable Care Act (ACA) protections.

- These are the same politicians that want to undo protections for pre-existing conditions and take away copay-free preventive care under the ACA — two key factors in helping women have healthy pregnancies. To support pregnant women, members of Congress should support legislation like the Protecting Pre-Existing Conditions & Making Health Care More Affordable Act, which would protect people living with pre-existing conditions, lower health care costs and reverse the administration's harmful sabotage of the ACA. And, these same people would dismantle our nation's Medicaid program, which covers nearly 50% of all births in our country and is a frontline program for helping women have healthy pregnancy outcomes. For example, Tennessee legislators approved a bill this month that would make the state the first to request approval from the administration for a Medicaid block

grant, a move that could potentially cut their Medicaid program and eliminate health coverage for thousands of low-income pregnant women.

They would do nothing to guarantee safe, supportive workplaces for pregnant and parenting people.

- **Pregnant workers** are often forced out of their jobs because they are denied **reasonable accommodations** that would enable them to have a healthy pregnancy. They lose the income they need to support their family. Truly supporting pregnant people means supporting legislation like The Pregnant Workers Fairness Act.
- A **national paid family and medical leave policy** would allow parents to care for new babies while remaining in the workforce. **Paid sick days** would help pregnant workers get the prenatal care they need. That's why you support the FAMILY Act and the Healthy Families Act.
- Pregnant people also need **fair pay**. Mothers with full-time, year-round jobs are paid 71 cents for every dollar paid to fathers. Supporting women and families means ensuring that mothers have fair pay so they can support their families.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help all people meet the dual demands of work and family. More information is available at NationalPartnership.org.