

## Testimony of the Center for Reproductive Rights

### **“Protecting Roe: Why We Need the Women’s Health Protection Act” Senate Judiciary Subcommittee on The Constitution**

**June 16, 2021**

Chairman Blumenthal, Ranking Member Cruz, and Members of the Subcommittee:

The Center for Reproductive Rights respectfully submits the following testimony to the Senate Judiciary Subcommittee on The Constitution in support of the Women’s Health Protection Act (S. 1975)(“the Act”). Since 1992, the Center for Reproductive Rights (“the Center”) has worked toward the time when the promise of reproductive freedom is enshrined in law in the United States and throughout the globe. We envision a world where every person participates with dignity as an equal member of society, regardless of gender—where governments around the world respect, protect and fulfill each person’s ability to make decisions about their reproductive health and life and have equitable access to the full range of reproductive health care services and information.

**The Women’s Health Protection Act is crucial legislation needed to safeguard access to abortion care throughout the United States, and to put an end to the countless waves of burdensome, medically unnecessary bans and restrictions preventing people from accessing the critical, time-sensitive abortion care they need.**

In its landmark 1973 decision, *Roe v. Wade*, and in a long line of subsequent decisions, the Supreme Court of the United States has affirmed that the Constitution’s guarantees of personal privacy and liberty protect a person’s right to end a pregnancy prior to viability.<sup>1</sup> Despite this constitutional guarantee, dozens of states have persistently introduced and passed hundreds of harmful, restrictive laws, creating widespread barriers to abortion care across the United States, particularly across the South and in parts of the Midwest. These attacks have only intensified in recent years, as dozens of states have introduced or enacted blatantly unconstitutional bans on abortion at various stages of pregnancy. Despite the onslaught of such measures, courts have consistently rejected recent state efforts to enact pre-viability bans on abortion in their gambit to overturn *Roe v. Wade*.<sup>2</sup> But now, the Supreme Court is poised to address a pre-viability abortion ban from Mississippi that is a direct challenge to *Roe* and the longstanding protections for abortion rights that build on that critical jurisprudence.<sup>3</sup> It is imperative that Congress protect access to abortion from the avalanche of state laws that ban, unduly burden, and present a substantial

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<sup>1</sup> See *Roe v. Wade*, 412 U.S. 113 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (plurality opinion); *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2320 (2016); *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2133 (2020) (plurality opinion).

<sup>2</sup> *Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246 (5th Cir. 2020) (striking down 15-week abortion ban), *cert. granted*, No. 19-1392 (U.S. May 17, 2021); *Planned Parenthood Ass’n of Utah v. Miner*, No. 2:2019cv00238 (D. Utah 2019) (granting preliminary injunction against 18-week gestational ban); *Robinson v. Marshall*, 415 F. Supp. 3d 1053 (M.D. Ala. 2019) (striking down total abortion ban); *Memphis Ctr. for Reprod. Health v. Slatery*, No. 3:20-cv-00501 (M.D. Tenn. 2020) (granting preliminary injunction against cascading gestational age bans).

<sup>3</sup> *Dobbs v. Jackson Women’s Health Org.*, *cert. granted* (U.S. May 17, 2021) (No. 19-1392).

obstacle to abortion access and violate the Constitution under any test. Moreover, these state laws are restricting the flow of interstate commerce in essential health care. Congress has previously exercised its power over interstate commerce to protect access to abortion services and it should do so again.<sup>4</sup>

The Center for Reproductive Rights has litigated hundreds of cases to protect and preserve access to critical reproductive health care. Currently, the Center has more than 30 cases pending in the courts to combat the attacks on reproductive rights, with close to 100 of these cases being litigated across the country, including by partner organizations like the American Civil Liberties Union and Planned Parenthood. While the courts remain a critical backstop against some of the most extreme unconstitutional abortion restrictions, litigation alone has not been enough to protect abortion access nationwide. Indeed, we have seen state legislatures intensify their relentless attacks on reproductive rights even as courts reject these efforts. Following the Supreme Court's decision in *Whole Woman's Health v. Hellerstedt*, striking down two Texas provisions intended to shut down abortion access in that state, the Texas legislature persisted in introducing abortion restrictions intended to restrict access and shut down clinics, including a 6-week ban signed into law on May 19<sup>th</sup> of this year.<sup>5</sup> Moreover, despite the Supreme Court's favorable ruling, many clinics forced to close as a result of the challenged Texas provisions remained shuttered in spite of the Supreme Court's victory.<sup>6</sup> Similarly, following the 2020 Supreme Court decision in *June Medical Services v. Russo*, striking down a Louisiana law targeted at providers in Louisiana, states across the U.S. introduced hundreds of bills restricting access.<sup>7</sup>

Our experience corroborates what every reader of a newspaper knows and what volumes of legislation and court decisions document: there is a longstanding, widespread, and growing pattern of unconstitutional state abortion restrictions that severely limits the availability of abortion care. This pattern includes the knowing passage of unconstitutional laws that hinder the delivery of health care and have lasting effects, even when these laws are later struck down in court. These cynical restrictions block and affect interstate commerce and undermine gender equality, which Congress has a prerogative and obligation to protect. The Women's Health Protection Act responds to urgent threats to a fundamental right and an essential component of health care.

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<sup>4</sup> When Congress passed the Freedom of Access to Clinic Entrances Act in 1994, all nine circuit courts to address the issue held that Congress has authority under the Commerce Clause to safeguard access to abortion services. See *Norton v. Ashcroft*, 298 F.3d 547, 556 (4th Cir. 2002) (citing cases); see also *U.S. v. Bird*, 401 F.3d 633, 634 (5th Cir. 2004) (reaffirming prior holding). Patients and providers cross state lines to obtain and provide abortion services. Providers also purchase goods and services in interstate markets in order to provide abortion services. The state restrictions addressed by WHPA affect the cost and availability of abortion services, and the settings in which people end their pregnancies.

<sup>5</sup> Jason Breslow & Sarah McCammon, *The Governor of Texas Has Signed a Law that Bans Abortion as Early as 6 Weeks*, NATIONAL PUBLIC RADIO (May 19, 2021) <https://www.npr.org/2021/05/19/998237349/the-governor-of-texas-has-signed-a-law-that-bans-abortion-as-early-as-6-weeks>.

<sup>6</sup> See Ashley Lopez, *Despite Supreme Court Win, Texas Abortion Clinics Still Shuttered*, KAISER HEALTH NEWS (Nov. 18, 2019) <https://khn.org/news/despite-supreme-court-win-texas-abortion-clinics-still-shuttered/>; Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90(5) CONTRACEPTION 496 (2014) (finding that, in the year following the implementation of Texas' abortion restrictions, the number of facilities providing abortion services in Texas declined by 46%).

<sup>7</sup> Elizabeth Nash & Lauren Cross, *2021 is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades*, GUTTMACHER INSTITUTE (May 18, 2021) <https://www.guttmacher.org/article/2021/04/2021-track-become-most-devastating-antiabortion-state-legislative-session-decades>.

Without federal statutory protections for providers and their patients, the ability of people across the nation to make fundamental personal decisions about their bodies, health, and families will remain under attack. Evidence overwhelmingly shows that these restrictions threaten the quality of patients' medical care and cause disproportionate harm for people already experiencing systemic barriers to care, including people working to make ends meet, Black, Indigenous and other People of Color (BIPOC), LGBTQ+ people, immigrants, young people, people with disabilities, and people living in rural or other medically underserved areas.<sup>8</sup>

Finally, as a human rights-based organization, we are acutely aware that the extremism of this deluge of abortion bans and restrictions is out of alignment with the global trend towards liberalization of abortion laws and international recognition that the ability to make deeply personal decisions about reproductive health care, including abortion, is central to individual autonomy and human rights.

**The Women's Health Protection Act**<sup>9</sup> would help to ensure that the right to abortion recognized nearly fifty years ago in *Roe v. Wade* is a reality for people in the United States, no matter what state they happen to live in. This bill would create a federal statutory right for clinicians to provide abortion care, and a corresponding right for their patients to receive abortion care, free from medically unnecessary restrictions and bans that single out abortion and impede access to care.

Congress can and must stop the further degradation of reproductive health care and protect the availability of abortion care by passing the Women's Health Protection Act.

### **I. The U.S. Constitution Protects Access to Abortion as a Fundamental Right, but this Right Is Now at Risk.**

The Supreme Court has repeatedly recognized that the Constitution's protections of liberty must include the right to make intimate decisions and profoundly important life choices about family, relationships, bodily integrity, and autonomy. Abortion sits within that set of essential rights—rooted in decades of interwoven legal decisions protecting liberty and privacy, including the right of parents to direct their children's upbringing and education, the right of familial association, and the right to contraception. *Roe v. Wade* and the Supreme Court's other decisions protecting the

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<sup>8</sup> There is extensive evidence that abortion restrictions and bans have a disproportionate and systemic impact on these populations. Women of color face enormous barriers to accessing reproductive health care because of racism, income inequality, and other forms of structural inequality. LGBTQ+ people, those living in poverty, those living in rural areas, and young people are also disproportionately impacted by state abortion restrictions. *See, e.g.,* IN OUR OWN VOICES, OUR BODIES, OUR LIVES, OUR VOICES: THE STATE OF BLACK WOMEN & REPRODUCTIVE JUSTICE POLICY REPORT (2017); Michelle Goodwin & Erwin Chemerinsky, PREGNANCY, POVERTY, AND THE STATE 1328-29 (2018); *ACOG v. FDA*, 2020 WL 7240396 (D. Md. Dec. 9, 2020); *ACOG v. FDA*, 2020 WL 3960625 (D. Md. Jul. 13, 2020).

<sup>9</sup> Women's Health Protection Act of 2021, S. 1975, 117th Cong. (2021) <https://www.congress.gov/bill/117th-congress/senate-bill/1975?r=1&s=1>. The Women's Health Protection Act is named in an acknowledgement that women have historically been disproportionately targeted and impacted by laws that restrict abortion and comprehensive reproductive care. However, the text of the bill recognizes that "not all people who become pregnant or need abortion services identify as women. Access to abortion services is critical to the health of every person regardless of actual or perceived race, color, national origin, immigration status, sex (including gender identity, sex stereotyping, or sexual orientation), age, or disability status. This Act's protection is inclusive of all pregnant people."

constitutional right to abortion are integral to the liberty decisions that followed in other areas of law, including recognition of the right of same-sex couples to marry.<sup>10</sup>

The Supreme Court recognized that the Constitution’s liberty protections encompass the right to make deeply personal decisions about whether and when to become a parent almost fifty years ago. The landmark decision, *Roe v. Wade*, held that the right to end a pregnancy is fundamental to a woman’s personal liberty.<sup>11</sup>

Since then, the Supreme Court has repeatedly reaffirmed *Roe*’s central holding, recognizing that a woman’s control over her own reproductive decisions is essential to her health, liberty, dignity, and autonomy. In *Planned Parenthood v. Casey*, the Supreme Court explained that “the ability of women to participate equally in the economic and social life of the nation has been facilitated by their ability to control their reproductive lives.”<sup>12</sup> In its analysis, the *Casey* Court recognized that, for decades, women have made deeply personal decisions about their lives and their relationships “in reliance on the availability of abortion.”<sup>13</sup>

The Court again upheld the right to abortion in 2016 in *Whole Woman’s Health v. Hellerstedt*,<sup>14</sup> and again in 2020 in *June Medical Services v. Russo*,<sup>15</sup> in each decision striking pretextual laws that impose severe barriers to abortion access while failing to further patient health and safety.

Now, less than a year later, the Court has made the extraordinary decision to grant certiorari in *Jackson Women’s Health Organization v. Dobbs*, a case that poses a direct threat to a central holding of *Roe v. Wade*.<sup>16</sup> The law at issue threatens abortion providers with severe penalties for providing abortion after 15 weeks of pregnancy, in defiance of nearly fifty years of Supreme Court precedent recognizing that the Constitution guarantees each person the right to decide whether to continue a pregnancy before viability. The future of this longstanding right, and the body of other rights built on its foundation, is now uncertain. One thing is clear: undermining the right to abortion weakens liberty protections for everyone.

## **II. A Persistent and Alarming Pattern of Unconstitutional State Laws Are Unduly and Substantially Burdening Abortion Care.**

For more than a decade, anti-abortion lawmakers and activists have engaged in a coordinated, nationwide strategy to burden abortion providers and their patients, fueling an unending cycle of harmful and unconstitutional state laws and court fights. These relentless and increasing attacks on abortion care are designed to ensure that providers and patients face insurmountable barriers

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<sup>10</sup> Amy Myrick, *Roe and Intersectional Liberty Doctrine*, CTR. FOR REPRODUCTIVE RIGHTS (2018), <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Liberty-Roe-Timeline-spread-forweb.pdf>.

<sup>11</sup> *Roe*, 410 U.S. at 155, 153.

<sup>12</sup> *Casey*, 505 U.S. at 835.

<sup>13</sup> *Casey*, 505 U.S. at 856.

<sup>14</sup> *Hellerstedt*, 36 S. Ct. at 2319-20.

<sup>15</sup> *June Med.*, 140 S. Ct at 2132-33.

<sup>16</sup> *Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246 (5th Cir. 2020), *cert. granted*, No. 19-1392 (U.S. May 17, 2021).

and that clinics will be forced to close—depriving people of the right to make the most fundamental decisions about their own reproductive health and lives.

#### A. Unconstitutional State Bans Directly Challenge *Roe* and Threaten to Eliminate Constitutional Protections for Abortion.

In recent years, states have become increasingly extreme in their tactics, enacting unconstitutional abortion bans that directly challenge *Roe*. In the first four months of 2021 alone, 69 abortion restrictions, including 9 bans, were enacted across 14 states.<sup>17</sup> Anti-abortion lawmakers and activists have explicitly discussed these laws as vehicles to overturn *Roe v. Wade*.<sup>18</sup> These bans fall into four different categories: pre-viability gestational bans, method bans, reason bans, and trigger bans. Regardless of their form, each of these bans is intended to strike at *Roe*'s central holding and restrict an individual's right to make one of life's mostly deeply personal decisions.

##### i. Pre-viability Gestational Bans

Despite decades of legal precedent universally invalidating pre-viability abortion bans, 23 states currently prohibit abortions after a fixed point in pregnancy, beginning as early as 6 weeks of pregnancy.<sup>19</sup> In every instance to date where these pre-viability bans have been challenged, they have been enjoined by court order.<sup>20</sup> Courts have repeatedly recognized that viability may differ with each pregnancy, and cannot be fixed at any particular point in pregnancy.<sup>21</sup>

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<sup>17</sup> Nash, *2021 is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades* *supra* note 7.

<sup>18</sup> Denise Burke, senior counsel for the anti-abortion Alliance Defending Freedom, has said these laws are part of her group's "strategic plan, that is a comprehensive, start-to-finish, from when we're considering legislation all the way up to the Supreme Court, to challenge *Roe*." Peter Montgomery, *ADF Attorneys Boast Of Plans For Further Restrictions, Then Bans On Abortion*, Right Wing Watch (Jan. 22, 2018), <http://www.rightwingwatch.org/post/adf-plans-first-trimester-abortion-restrictions-then-total-bans-as-it-fights-roe-in-the-courts/>.

<sup>19</sup> An additional 20 states impose a ban at viability. *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INSTITUTE (June 1, 2021), <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions>.

<sup>20</sup> *See, e.g., Bryant v. Woodall*, 363 F. Supp. 3d 611 (M.D.N.C. 2019) (20-week ban), *appeal pending on other grounds*, No. 19-1685 (4th Cir. June 26, 2019); *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019) (15-week ban), *cert. granted*, No. 19-1392 (U.S. May 17, 2021); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 981 (2016) (6-week ban); *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 895 (2016) (12-week ban); *McCormack v. Herzog*, 788 F.3d 1017 (9th Cir. 2015) (equivalent of 22-week LMP ban); *Isaacson v. Horne*, 716 F.3d 1213 (9th Cir. 2013), *cert. denied*, 571 U.S. 1127 (2014) (20-week ban); *Jane L. v. Bangert*, 102 F.3d 1112 (10th Cir. 1996) (equivalent of 22-week LMP ban); *Sojourner T v. Edwards*, 974 F.2d 27 (5th Cir. 1992), *cert. denied*, 507 U.S. 972 (1993) (ban at all gestational ages); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366 (9th Cir. 1992), *cert. denied*, 506 U.S. 1011 (1992) (ban at all gestational ages).

<sup>21</sup> *See, e.g., Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 64 (1976) (finding "it is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period"); *Woodall*, 363 F. Supp. 3d at 611 (finding "the week-specific point of viability cannot be relevant to this dispute because the Supreme Court has clearly advised that a state legislature may never fix viability at a specific week but must instead leave this determination to doctors."); *Reprod. Health Servs. of Planned Parenthood of St. Louis Region, Inc. v. Parson*, Case No. 2:19-cv-4155-HFS (W.D. Mo. Aug. 28, 2019) (finding "however formulated, the legislation on its face conflicts with the Supreme Court ruling that neither legislative nor judicial limits on abortion can be measured by specified weeks of development of a fetus; instead, 'viability' is the sole test for a State's authority to prohibit abortions where there is no maternal health issue.").



Nonetheless, state lawmakers continue to pass these onerous and unconstitutional bans on abortion, some prohibiting abortion as early as 6 weeks after a person’s last period—i.e., two weeks after a missed regular period and before many people even know they are pregnant. In 2018, two states, Mississippi and Louisiana, banned abortion at 15 weeks.<sup>22</sup> In 2019, following a shift in the makeup of the Supreme Court, anti-abortion state lawmakers enacted a wave of increasingly extreme and blatantly unconstitutional abortion bans in hopes of presenting the Court with an opportunity to overturn *Roe*’s central holding.<sup>23</sup> Missouri’s legislation banned abortion at eight weeks and as a back-up, also banned abortion at three other gestational stages, in anticipation of litigation over the constitutionality of each ban at each gestational stage.<sup>24</sup> Georgia, Iowa, Kentucky, Louisiana, Mississippi, Ohio, and Tennessee all enacted 6-week bans.<sup>25</sup> Alabama banned abortion completely.<sup>26</sup> In 2021, Idaho, Oklahoma, South Carolina, and most recently, Texas also passed bans on abortion after 6 weeks.<sup>27</sup>

Mississippi’s 15-week ban is the first of those recent bans to be heard by the Supreme Court and potentially to deliver on this cynical strategy. The Supreme Court’s decision to consider the question of whether all pre-viability prohibitions on abortion are unconstitutional is deeply concerning and threatens nearly 50 years of Supreme Court precedent going back to *Roe*, recognizing that the Constitution guarantees each person the right to decide whether to continue a pre-viability pregnancy.

## ii. Method Bans

Many states have passed laws that make it a crime for a doctor to perform a standard dilation and evacuation (“D&E”) procedure, the safest and most common method of abortion starting early in the second trimester and the standard of care for surgical abortion after 14 to 15 weeks. These laws have been enacted in West Virginia, Texas, Kansas, Ohio, Oklahoma, Arkansas, Louisiana,

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<sup>22</sup> H.B. 1510, 2018 Reg. Sess. (Miss. 2018) <http://billstatus.ls.state.ms.us/documents/2018/pdf/HB/1500-1599/HB1510SG.pdf>; S.B. 181, 2018 Reg. Sess. (La. 2018) <http://www.legis.la.gov/legis/ViewDocument.aspx?d=1102051>.

<sup>23</sup> Elizabeth Nash, *A Surge in Bans on Abortion as Early as Six Weeks, Before Most People Know they are Pregnant*, GUTTMACHER INSTITUTE (May 30, 2019).

<sup>24</sup> *Reproductive Health Services of Planned Parenthood of the St. Louis Region, Inc. et al. v. Parson*, No. 2:19-cv-4155-HFS (W.D. Mo. Aug. 27, 2019).

<sup>25</sup> *Memphis Ctr. For Reprod. Health v. Slatery*, No. 3:20-CV-00501, 14 2020 WL 4274198 (M.D. Tenn. July 24, 2020) (granting preliminary injunction), *appeal filed*, No. 20-5969 (6th Cir. Aug. 24, 2020); *Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246 (5th Cir. 2020) (affirming preliminary injunction of 6-week ban); *Women of Color Reprod. Justice Collective v. Kemp*, 472 F. Supp. 3d 1297 (N.D. Ga. 2020), *appeal filed*, No. 20-13024 (11th Cir. Aug. 11, 2020); *EMW Women’s Surgical Ctr., P.S.C. v. Beshear*, No. 3:19-CV-178-DJH, 2019 WL 1233575 (W.D. Ky. Mar. 15, 2019) (temporary restraining order); *Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 804 (S.D. Ohio 2019) (preliminary injunction); *Planned Parenthood of the Heartland v. Reynolds*, No. EQCE83074, 2019 WL 312072 (Iowa Dist. Ct. Polk Cty. Jan. 22, 2019); S.B. 184, 2019 Reg. Sess. (La. 2019) <http://www.legis.la.gov/legis/ViewDocument.aspx?d=1140119> (enacted “heartbeat” ban that would have become effective had the Fifth Circuit upheld Mississippi’s ban).

<sup>26</sup> *Robinson v. Marshall*, 415 F. Supp. 3d 1053 (M.D. Ala. 2019) (striking down near-total abortion ban).

<sup>27</sup> S.B. 8, 87th Leg. Sess. (Tex. 2021) <https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB00008F.pdf#navpanes=0>; H.B. 366, 66th Leg. Reg. Sess. (Idaho 2021) <https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2021/legislation/H0366.pdf>; H.B. 2441, 58th Leg. Reg. Sess. (Okla. 2021) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2021-22%20ENR/hB/HB2441%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/hB/HB2441%20ENR.PDF); S.B. 1, 124th Gen. Assemb. (S.C. 2021) [https://www.scstatehouse.gov/sess124\\_2021-2022/bills/1.htm](https://www.scstatehouse.gov/sess124_2021-2022/bills/1.htm).

Mississippi, Alabama, Kentucky, and most recently, in Indiana and North Dakota (enacted in 2019 and 2020, respectively).<sup>28</sup> Under these criminal bans, the states’ proposed alternatives to a standard D&E are considered by medical experts and federal courts to be “experimental” and “unreliable,” and carry “unknown risks” with “no medical benefits to the woman.”<sup>29</sup>

In banning the standard D&E method, states have proposed that physicians instead perform medically unnecessary and often experimental methods of causing fetal demise before beginning the procedure. Courts have repeatedly rejected such bans, finding that these proposals would not be safe or feasible.<sup>30</sup> These bans would leave people seeking abortions with options that are medically unnecessary and invasive, or with none at all, especially in the second trimester.<sup>31</sup>

Additionally, the arguments states use to try to defend this current wave of method bans rest on opposition to abortion itself and could be cynically deployed to incrementally ban all methods of abortion. These tactics have been in use for over two decades, with anti-abortion groups first advancing laws banning a rarely used method of second-trimester abortion, dilation and extraction,

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<sup>28</sup> *State Policy Trends 2020: Reproductive Health and Rights in a Year Like No Other*, GUTTMACHER INSTITUTE (Dec. 2020) <https://www.guttmacher.org/article/2020/12/state-policy-trends-2020-reproductive-health-and-rights-year-no-other>; *State Policy Trends 2019: A Wave of Abortion Bans, But Some States are Fighting Back*, GUTTMACHER INSTITUTE (Dec. 2019) <https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back>.

<sup>29</sup> *Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1060 (E.D. Ark. 2017); *see also W. Alabama Women’s Ctr. v. Miller*, 299 F. Supp. 3d 1244, 1270-80 (M.D. Ala. 2017).

<sup>30</sup> *EMW Women’s Surgical Ctr., P.S.C. v. Friedlander*, 960 F.3d 785, 798 (6th Cir. 2020) (affirming district court’s conclusion that “none of [the State’s proposed demise] methods is a feasible workaround to” a D&E ban), *affirming EMW Women’s Surgical Ctr., P.S.C. v. Meier*, 373 F. Supp. 3d 807, 823 (W.D. Ky. 2019) (concluding the State’s three “proposed fetal-demise methods are not feasible” because of “risks, technical difficulty, untested nature, time and cost associated with performing them, and the lack of training opportunities”); *W. Ala. Women’s Ctr. v. Williamson*, 900 F.3d 1310, 1324-25, 1327 (11th Cir. 2018) (affirming district court’s findings that “the State’s proposed fetal demise methods were not safe, effective, [or] available,” and that “their attendant risks; their technical difficulty; their untested nature; the time and cost associated with performing them; the lack of training opportunities; and the ability to recruit experienced practitioners to perform them—support the conclusion that the [D&E ban]” would impose substantial obstacles), *affirming W. Ala. Women’s Ctr. v. Miller*, 299 F. Supp. 3d 1244, 1268, 1279 (M.D. Ala. 2017) (concluding that UCT, KCl, and digoxin were “not feasible” fetal demise methods), cert. denied, 139 S. Ct. 2606 (2019); *Bernard v. Individual Members of Med. Licensing Bd.*, 392 F. Supp. 3d 935, 962 (S.D. Ind. 2019) (finding that “none of the proffered alternatives serve as an adequate substitute for the standard D&E procedure” and that they “subject women to increased risk of physical, psychological, and economic harm for no medical benefit” and “variously increase the cost of the procedure, the duration and pain of the procedure, the medical risks of the procedure, or all three”); *Planned Parenthood of Sw. Ohio Region v. Yost*, 375 F. Supp. 3d 848, 867 (S.D. Ohio 2019) (finding that “the State’s suggested demise options have serious drawbacks”); *Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1065 (E.D. Ark. 2017) (concluding that the State’s “proposed methods” of digoxin, KCl, and UCT “are not feasible for inducing fetal demise before the standard D&E procedure”), *vacated and remanded on other grounds*, 968 F.3d 912 (8th Cir. 2020) (per curiam); *Hopkins v. Jegley*, No. 4:17-cv-00404-KGB, 2020 WL 7632075, at \*31 (E.D. Ark. Dec. 22, 2020) (finding, after remand, D&E ban is a substantial obstacle); *Hodes & Nausser, MDs, P.A. v. Schmidt*, 440 P.3d 461, 498 (Kan. 2019) (concluding that State’s proposed workarounds “carry increased risks, are untested in some circumstances, require extra steps and time, and may be impossible in some cases,” and would subject patients to “risks, uncertainty, and hardship”); *see also Tulsa Women’s Reprod. Clinic v. Hunter*, No.118,292 (Okla. Sup. Ct. Nov. 4, 2019) (enjoining D&E ban pending resolution of appeal of summary trial court order containing no findings of fact).

<sup>31</sup> *Whole Woman’s Health v. Paxton*, 280 F. Supp. 3d 938, 946-47 (W.D. Tex. 2017).

that they characterized as “partial birth abortion.”<sup>32</sup> This effort culminated in a federal ban on the dilation and extraction method—which survived constitutional scrutiny only due to the wide availability of the D&E method of abortion during the second trimester.<sup>33</sup> Yet, lawmakers hostile to abortion next began passing laws banning or severely restricting the D&E procedure, again seeking to incite discomfort by labeling the medical procedure with the medically inaccurate and inflammatory term, “dismemberment abortion.”<sup>34</sup> When defending a D&E ban in 2017, Texas characterized the D&E method as “brutal” without drawing any distinction between that method and the only other abortion method used during the second trimester.<sup>35</sup> States are already laying the groundwork to apply these tactics to medication abortion (a safe and effective non-surgical procedure that can be used up to 11 weeks of pregnancy), referring to it as “chemical abortion” and claiming it is dangerous despite abundant scientific evidence to the contrary.<sup>36</sup> If these arguments are accepted by the courts, states could ban abortion procedures one-by-one based on their perceived “brutality,” regardless of the medical providers’ evidence-based judgment and the empirical evidence as to the safest and most effective method, and irrespective of the best interests of the patient.<sup>37</sup>

### iii. Reason Bans

Reason bans prohibit abortion if sought for a particular reason—for example, abortion sought on account of the race or sex of a fetus, or a fetal diagnosis. The primary purpose of these types of bans is to restrict access to abortion care, not to address racial injustice, gender-based discrimination, or support people with disabilities to live and thrive in their communities.<sup>38</sup> Because these bans apply before viability, they are flatly unconstitutional under *Roe v. Wade*.

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<sup>32</sup> See, e.g., 1997 S.C. Acts 11 (West) (banning “partial birth abortion”); 2005 Wis. Act 277 (West); Partial-Birth Abortion Ban Act of 1997, 1997 N.J. Laws ch. 262 (West); 1997 Ariz. Sess. Laws Ch. 83 § 1, amend. 2009 Ariz. Sess. Laws ch. 170, § 1 (West); 1998 Okla. Sess. Laws ch. 122 (West) (banning “partial birth abortion”); 2003 Va. Acts. ch. 961 (Apr. 2, 2003) (banning “partial birth abortions”); 2007 La. Acts 477 (West) (banning “partial birth abortion”).

<sup>33</sup> See 18 U.S.C.A. § 1531 (West 2003); *Gonzales v. Carhart*, 550 U.S. 124, 164 (2007) (holding the Partial-Birth Abortion Ban Act of 2003 did not impose an undue burden on abortion access in part because alternatives were available to the prohibited procedure, including D&E).

<sup>34</sup> See, e.g., Kansas Unborn Child Protection from Dismemberment Abortion Act, 2015 Kan. Sess. Laws ch. 22 (West); Unborn Child Protection from Dismemberment Abortion Act, 2016 Ala. Laws 397 (West); Oklahoma Unborn Child Protection from Dismemberment Abortion Act, 2015 Okla. Sess. Laws ch. 59 (West); 2019 Ind. Acts P.L. 93 (West) (banning the D&E method (defined as “dismemberment abortion”) in most circumstances); The Arkansas Unborn Child Protection from Dismemberment Abortion Act, 2017 Ark. Acts 45 (West); 2017 Tex. Gen. Laws ch. 441 (West).

<sup>35</sup> Appellee’s Br. at 35, *Whole Woman’s Health v. Paxton* (5th Cir. 2018) (No. 17-51060).

<sup>36</sup> See e.g. 63 OK Stat § 63-1-729a (2016) (referring to medication abortion as “chemical abortion” and stating its purpose is to “protect women from the dangerous and potentially deadly off-label use of abortion-inducing drugs”).

<sup>37</sup> Appellee’s Br. at 37, *Whole Woman’s Health v. Paxton* (5th Cir. 2018) (No. 17-51060).

(quoting the District Court as being “unaware of any other medical context that requires a doctor in contravention of the doctor’s medical judgment and the best interest of the patient to conduct a medical procedure that delivers no benefit to the woman”).

<sup>38</sup> See *Shifting the Frame on Disability Rights for the Reproductive Rights Movement*, CENTER FOR REPRODUCTIVE RIGHTS (Mar. 2017) <https://reproductiverights.org/wp-content/uploads/2020/12/Disability-Briefing-Paper-FINAL.pdf>.



Four states—Arkansas, Kentucky, Missouri, and Utah—enacted bans based on the patient’s reason for seeking an abortion in 2019, with all four banning abortion of a fetus that has or may have Down syndrome.<sup>39</sup> Kentucky and Missouri also banned abortion based on the race or predicted sex of the fetus, and Kentucky also enacted a ban on abortion “for a diagnosis of fetal anomaly.”<sup>40</sup> In 2020, Mississippi and Tennessee enacted reason bans based on sex, race, and fetal diagnosis.<sup>41</sup> Including these bans enacted in 2021, 11 states currently enforce sex-based reason bans, while four states enforce race-based reason bans, and five states enforce reason bans based on a fetal diagnosis.<sup>42</sup> Thus far in 2021, one state (Arizona) has enacted a reason ban.<sup>43</sup>

These reason bans interfere in the provider-patient relationship, forcing providers to question peoples’ motivations for obtaining abortions.<sup>44</sup> They are not evidence-based<sup>45</sup> and advance racist stereotypes about women of color, specifically Asian American and Pacific Islander (AAPI) women, Black women, and Latina women.<sup>46</sup> Reason bans on abortion based on a fetal diagnosis are not advanced by people within the disability community, and threaten access to abortion and reproductive health care for women and girls with disabilities, who are more than half of all persons with disabilities in the U.S.<sup>47</sup>

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<sup>39</sup> *Wave of Abortion Bans*, *supra* note 28.

<sup>40</sup> *Id.*

<sup>41</sup> H.B. 1295, 2020 Reg. Sess. (Miss. 2020) <http://billstatus.ls.state.ms.us/documents/2020/pdf/HB/1200-1299/HB1295SG.pdf>; S.B. 2196, 111th Gen. Assemb. (Tenn. 2020) <https://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=SB2196&GA=111>.

<sup>42</sup> *Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INSTITUTE (May 19, 2021) <https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly>.

<sup>43</sup> S.B. 1457, 55th Leg. (Ariz. 2021) <https://www.azleg.gov/legtext/55leg/1R/bills/SB1457P.pdf>.

<sup>44</sup> See *ACOG Statement on Abortion Reason Bans*, AM. COLL. OBSTETRICS & GYNECOLOGY (Mar. 10, 2016) <https://www.acog.org/news/news-releases/2016/03/acog-statement-on-abortion-reason-bans>.

<sup>45</sup> While sex-selective abortions are performed in some other countries due to a strong preference for sons, there is limited and inconclusive evidence that abortions are being obtained for such reasons in the United States, and can lead to the stigmatization of Asian-American women seeking abortions. Anti-choice activists use the higher rates of abortion among Latinx and African-American people as proof that providers are pushing abortion on people from these communities, however, the higher abortion rates among those communities is reflective of higher rates of unintended pregnancies, and there is no evidence that people from those communities are being forced into abortions by providers. *Banning Abortion in Case of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INSTITUTE (Jan. 2020) <https://www.guttmacher.org/evidence-you-can-use/banning-abortions-cases-race-or-sex-selection-or-fetal-anomaly>.

<sup>46</sup> *Id.* See Brief of Black Women’s Health Imperative as Amicus Curiae in Support of Plaintiffs-Appellants, *NAACP v. Horne*, No. 13-17247 (9th Cir., 2014) <https://www.aclu.org/legal-document/naACP-et-al-v-tom-horne-et-al-amicus-brief-black-womens-health-imperative-support-pts> (describing how reason bans harm Black women by codifying and perpetuating the stereotype that black women are too ignorant or immoral to make responsible reproductive choices); Brian Citro et al., *Replacing Myths with Facts: Sex-Selective Abortion Laws in the United States*, NAT’L ASIAN PAC. AM. WOMEN’S FORUM (2014) <https://static1.squarespace.com/static/5ad64e52ec4eb7f94e7bd82d/t/5d2ca0d5cd54a90001b97595/1563205847373/replacing-myths-with-facts.pdf> (addressing myths surrounding sex-selective abortion and the Asian American community, and concluding that sex-selective abortion bans are based on harmful stereotypes of Asian Americans, and are likely to lead to denial of health services to Asian American women).

<sup>47</sup> S.E. Smith, *Disabled People are Tired of Being a Talking Point in the Abortion Debate*, VOX (May 29, 2019) <https://www.vox.com/first-person/2019/5/29/18644320/abortion-ban-2019-selective-abortion-ban-disability>; *Shifting the Frame on Disability Rights for the Reproductive Rights Movement*, *supra* note 38.

#### *iv. Trigger Bans*

The final type of abortion bans are “trigger bans,” which are laws that are intended to ban abortion in a given state at a future date if the U.S. Supreme Court overrules *Roe v. Wade*, in whole or in part, or if an amendment is made to the U.S. Constitution that allows states to prohibit abortion. Congressional action in the face of these trigger bans is warranted for several reasons. A trigger ban—like the one recently enacted by Texas—is unconstitutional if it will “wholly” prohibit abortion following a Supreme Court decision that “partly” allows states to ban abortion.<sup>48</sup> They promise to interfere with interstate commerce involving health care, which Congress has the authority to safeguard. And legislation banning abortion creates the misimpression among pregnant people that abortion is not legal in their state.<sup>49</sup>

As of 2007, only four states had enacted trigger bans: Louisiana, Mississippi, North Dakota, and South Dakota.<sup>50</sup> However, with the changing composition of the Supreme Court, more states hostile to abortion rights have enacted these laws. In the last 3 years, an additional *eight* states (Arkansas, Idaho, Kentucky, Missouri, Oklahoma, Tennessee, Utah, and, in May 2021, Texas) enacted legislation intended to ban abortion if the Supreme Court were to overturn *Roe v. Wade*.<sup>51</sup> A total of twelve states now have “trigger bans” in place.<sup>52</sup>

#### B. State Laws Targeting Abortion Providers for Overregulation Threaten to Eliminate Access to Abortion Care.

In addition to the wave of unconstitutional state abortion bans, many states have also enacted other medically unnecessary, onerous, and cumbersome laws and regulations that impose substantial burdens on access to abortion, under the false guise of protecting pregnant people’s health, and that which are not imposed on comparable outpatient services or common medical procedures that may carry greater risk. Each of these state laws and regulations—totaling in the hundreds—is a part of a complex obstacle course of restrictions that providers and patients must navigate. The cumulative effect and purpose of these restrictions is to make it exceedingly difficult, and in some cases impossible, to provide or obtain abortion care, functionally denying the right to abortion to

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<sup>48</sup> A similar issue prompted Congress to rely on the Commerce Clause to enact the Freedom of Access to Clinics Act in 1994. A Supreme Court decision eliminated a legal tool that had been used to protect access to abortion. In response to that decision, Congress and the courts recognized Congress’s prerogative under the Commerce Clause to protect access to clinics. See Sen. Rep. No. 103-117, at 18, 30-31 (1993) (“S. 636 is therefore necessary to fill the gap in the law left by the *Bray* decision” and “Congress has clear constitutional authority to enact the Freedom of Access to Clinic Entrances Act under the Commerce Clause, which gives it authority to regulate interstate commerce.”).

<sup>49</sup> Maria F. Gallo et al., *Passage of Abortion Ban and Women’s Accurate Understanding of Abortion Legality*, AM. J. OBSTETRICS & GYNECOLOGY (2021), <https://doi.org/10.1016/j.ajog.2021.02.009>.

<sup>50</sup> N.D. Cent. Code §§ 12.1-31-12 (2007), amended by 2019 N. D. Laws Ch. 126 (H.B. 1546); Miss. Code Ann. §§ 41-41- 45 (2007); LA. Stat. Ann. § 40:1061 (2006); 2005 S.D. Sess. Laws ch. 187, §§ 1–4, 7 (2005).

<sup>51</sup> See *Abortion Policy in the Absence of Roe*, GUTTMACHER INSTITUTE (May 18, 2021) <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe>; H.B. 1280, 87th Leg. Sess. (Tex. 2021) <https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB01280F.pdf#navpanes=0>.

<sup>52</sup> *Id.*

many people.<sup>53</sup> These restrictions can further be broken down into three categories: targeted restrictions on abortion providers (“TRAP laws”), restrictions that burden the pregnant person’s decision-making process, and laws restricting the use of telemedicine for the provision of medication abortion.

*i. State TRAP Laws (Targeted Restrictions of Abortion Providers)*

TRAP laws are restrictions that single out and limit the availability of abortion, often shutting down abortion clinics, in the purported name of protecting women and their health. These laws are distressingly common and unconstitutional. TRAP laws target abortion providers for medically baseless and costly requirements, related to the physical plant of a clinic, equipment, staffing, hospital transfer arrangements, and hospital affiliations or credentials of individual providers.<sup>54</sup> TRAP laws infamously have shut down clinics unless they widen their hallways, spend millions of dollars to retrofit their facilities to hospital-like standards, or hire only doctors who are hospitalists affiliated with a local hospital to perform abortion, which is a non-hospital, outpatient procedure.<sup>55</sup> These requirements and limitations are not necessary or appropriate for abortion care—one of safest and most common outpatient medical procedures performed in the United States<sup>56</sup>—and are not imposed on facilities where comparable medical procedures are provided.<sup>57</sup>

TRAP laws are widespread and impose an undue and substantial burden on abortion access throughout the country. Currently, 23 states have laws that regulate abortion providers and facilities beyond what is necessary to ensure patients’ safety.<sup>58</sup> Seventeen of those states have onerous licensing schemes for abortion facilities, many of which are comparable or equivalent to

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<sup>53</sup> See e.g., Elizabeth Nash, *Louisiana Has Passed 89 Abortion restrictions Since Roe: It’s About Control, Not Health*, GUTTMACHER INSTITUTE (June 29, 2020) (describing 89 abortion restrictions enacted in Louisiana since 1973, and the ways in which the “labyrinth of abortion restrictions” create different barriers that, working together, limit access to services and stigmatize abortion); Amended Compl., *June Med. Svs. v. Gee*, Case No. 3:17-cv-00404-BAJ-RLB (M.D. La. June 11, 2018) (ECF 87); Complaint at ¶¶ 68–82, *Whole Woman’s Health Alliance v. Paxton*, Case No. 1:18-CV-00500 (W.D. Tex. June 14, 2018) (ECF 1); Complaint at ¶¶ 28–81, *Whole Woman’s Health Alliance v. Hill*, Case No. 1:18-cv-1904 (S.D. Ind. June 21, 2018) (ECF 1); Complaint, *Falls Church Healthcare Center v. Oliver*, Case No. 3:18-cv-00428-HEH (E.D. Va. 2018) (ECF 1).

<sup>54</sup> *Targeted Regulation of Abortion Providers*, GUTTMACHER INSTITUTE (June 1, 2021), <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers>

<sup>55</sup> *What Are TRAP Laws?*, PLANNED PARENTHOOD ACTION FUND (last visited May 24, 2021) <https://www.plannedparenthoodaction.org/issues/abortion/trap-laws>.

<sup>56</sup> National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 1-16 (2018), <https://doi.org/10.17226/24950>; *Whole Woman’s Health*, 136 S. Ct. at 2311, 2315; Weitz TA et al., *Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver*, AMERICAN JOURNAL OF PUBLIC HEALTH, 103(3):454–461 (2013); Upadhyay UD et al., *Incidence of emergency department visits and complications after abortion*, OBSTETRICS & GYNECOLOGY, 125(1):175–183 (2015).

<sup>57</sup> See, e.g., *Whole Woman’s Health v. Hellerstedt*, 136 S.Ct. 2292, 2315 (2016) (noting that childbirth is 14 times more likely than abortion to result in death, colonoscopy has a mortality rate 10 times higher than abortion, and that medical treatment for an incomplete miscarriage often involves an identical procedure to that involved in a nonmedical abortion, but often takes place outside of a hospital or surgical center); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 789 (7th Cir. 2013) (noting that no other comparable procedure outside a hospital, including colonoscopy, arthroscopic, and laparoscopic procedures, even under general anesthesia, is required by Wisconsin law to be performed by doctors with hospital admitting privileges).

<sup>58</sup> *Targeted Regulation of Abortion Providers*, *supra* note 54.

licensing standards for ambulatory surgical centers, rather than the standards imposed on providers of comparable, outpatient medical care, such as OB/GYN offices.<sup>59</sup>

Eight states specify that abortion providers must be located at a location within a minimum distance from the nearest hospital, and six states require facilities to have transfer agreements with hospitals.<sup>60</sup> Additionally, 11 states have laws in effect requiring that physicians have some affiliation with a local hospital, either through admitting privileges or another arrangement.<sup>61</sup> Eight additional states' admitting privileges requirement laws have been either temporarily or permanently enjoined.<sup>62</sup>

In enacting these regulations, states place a disproportionate burden on abortion providers by treating abortion differently from other comparable medical procedures. The Supreme Court recognized this disparity in *Whole Woman's Health v. Hellerstedt*, noting that abortion is "much safer, in terms of minor and serious complications, than many common medical procedures not subject to such intense regulation and scrutiny."<sup>63</sup> The Court in *Whole Woman's Health* observed that Texas's TRAP requirements that abortion clinics outfit themselves as ambulatory surgical centers and hire only doctors with admitting privileges at local hospitals provided no benefit but would shut down three-quarters of Texas's abortion clinics, and that such laws unconstitutionally infringe on people's access to abortion care.<sup>64</sup>

The hallmark of TRAP laws is that they impede abortion care while purporting to protect women, but do not increase patient safety.<sup>65</sup> Rather, they make abortion more difficult and expensive for patients to obtain, and make compliance so difficult that many abortion providers have had to close

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<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> See, e.g., *June Med.*, 140 S. Ct. 2103 (2020); *Adams & Boyle v. Slatery*, No. 3:15-cv-00705 (M.D. Tenn. April 14, 2017); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016); *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015), cert. denied, 136 S. Ct. 2545 (Mem) (2016); *West Ala. Women's Ctr. v. Williamson*, 120 F. Supp. 3d 1296 (2015); *Jackson Women's Health Org. v. Currier*, 760 F.3d 448 (2014), cert. denied, 136 S. Ct. 2536 (2016); *Hodes & Nauser v. Moser*, Case No. 2011-cv-1298 (D. Kan. May 18, 2012); *Burns v. Cline*, 387 P.3d 348 (Okla. 2016).

<sup>63</sup> *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. at 2302 (citing *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 681 (W.D. Tex. 2014)).

<sup>64</sup> *Id.* The Appendix to the Court's decision in *Whole Woman's Health v. Hellerstedt* compares abortion to other common comparable medical procedures, including colonoscopies, vasectomies, endometrial biopsies, plastic surgery, and more. *Id.* at 2302.

<sup>65</sup> Fewer than 0.3% of abortion patients in the United States experience a major complication that requires hospitalization. Additionally, federal law requires that a patient in need of treatment be treated by any hospital, regardless of whether or where her abortion provider has admitting privileges. The standards imposed by TRAP laws cannot be justified as protecting patients' health and safety, and go well beyond what is necessary to ensure clinics are prepared to handle an emergency. See, e.g., ACOG, *Increasing Access to Abortion* (Nov. 2014, reaffirmed 2019), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf>; *Evidence You Can Use: Targeted Regulation of Abortion Providers (TRAP) Laws*, GUTTMACHER INSTITUTE (Jan. 2020) <https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws#trap>; NATIONAL ABORTION FEDERATION, *Clinical Policy Guidelines for Abortion Care* (2020) <https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2020-CPGs-Final-for-web.pdf>.

their doors.<sup>66</sup> These regulations and closures lead to delays in obtaining abortion services, which increase both the risks and costs associated with having an abortion.<sup>67</sup> These pretextual laws restricting and reducing the provision of abortion care mean “[p]atients seeking [abortion care] are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered.”<sup>68</sup>

Despite *Whole Woman’s Health*, and the Court’s ruling against an identical admitting privileges law in Louisiana in *June Medical Services v. Russo*, states have continued enacting and enforcing TRAP laws that provide no medical benefits.<sup>69</sup> For example, at least four states have introduced admitting privileges or transfer agreement laws in 2021.<sup>70</sup>

## ii. Mandatory Delay, Two-Trip, and Biased Counseling Laws

Even though all health care providers are required by state law and their own ethical obligations to obtain informed consent, the majority of states impose abortion-specific informed consent and mandatory counseling laws that are not imposed for other medical procedures and not evidence-based.<sup>71</sup> Such laws are part of the widespread pattern and practice of states singling out abortion for medically unnecessary and more restrictive regulation—despite overwhelming data on the

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<sup>66</sup> The number of abortion clinics in Texas fell sharply between 2013 and 2014 due to admitting privilege requirements, more than tripling the number of Texas women whose closest abortion clinic was more than 100 miles away. *Whole Woman’s Health v. Lakey*, 46 F. Supp. 3d 673, 681 (W.D. Tex. 2014)). Louisiana’s identical admitting privileges requirement would have left that state with only one abortion provider had the Supreme Court allowed it to go into effect. *June Med.*, 140 S. Ct. 2103 (2020). In 2013, the Virginia Department of Health estimated that compliance with new regulations at clinics would cost up to \$1 million per site, an exorbitantly expensive cost for abortion providers. *Evidence You Can Use: TRAP Laws*, *supra* note 65. A district court also struck down an Indiana licensing scheme, which included a registration requirement as well as a requirement of “reputable and responsible character.” *Whole Woman’s Health Alliance v. Hill*, 388 F. Supp. 3d 1010 (S.D. Ind. 2019).

<sup>67</sup> While the risks of complications from abortion are extremely small at any point, risk increases later in pregnancy. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. at 2311. Delays in seeking an abortion also impose significant burdens on poor women, as the cost of an abortion often increases later in pregnancy. *Evidence You Can Use: TRAP Laws*, *supra* note 65.

<sup>68</sup> *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. at 2318.

<sup>69</sup> See *June Med.*, 140 S. Ct.; *EMW Women’s Surgical Center, P.S.C. v. Friedlander*, 978 F.3d 418 (6th Cir. 2020); *Whole Woman’s Health Alliance v. Hill*, 937 F.3d 864 (7th Cir. 2019), *cert. denied*, 141 S. Ct. 189 (2020).

<sup>70</sup> S.B. 527, 93rd Gen. Assemb. (Ark. 2021).

<https://www.arkleg.state.ar.us/Bills/FTPDocument?path=%2FBills%2F2021R%2FPublic%2FSB527.pdf>; H.B. 460, 2021 Reg. Sess. (Ky. 2021) [https://apps.legislature.ky.gov/recorddocuments/bill/21RS/hb460/orig\\_bill.pdf](https://apps.legislature.ky.gov/recorddocuments/bill/21RS/hb460/orig_bill.pdf); S.B. 779, 58th Leg. (Okla. 2021) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2021-22%20ENR/SB/SB779%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/SB/SB779%20ENR.PDF); S.B. 1546, 87th Leg. (Tex. 2021) <https://capitol.texas.gov/Search/DocViewer.aspx?ID=87RSB015461B&QueryText=%22S.B.+1546%22&DocType=B>.

<sup>71</sup> See *Counseling and Waiting Periods for Abortion*, GUTTMACHER INSTITUTE (June 1, 2021) <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>.



safety of abortion care,<sup>72</sup> and the high levels of decisional certainty among people who decide to have abortions.<sup>73</sup>

States have enacted more and more extreme versions of these laws, including by increasing the mandatory delay period for patients seeking abortion from 24 hours to 72 hours;<sup>74</sup> forcing patients to consult with a Crisis Pregnancy Center (“CPC”) before receiving an abortion (which is intended to coerce the patient into not having the abortion);<sup>75</sup> and forcing providers to read state-scripted or mandatory information to patients, which can be biased and medically inaccurate.<sup>76</sup> Many states have passed laws of this kind that unduly and substantially burden the right to abortion.<sup>77</sup>

The most extreme state schemes impose several layers of “informed consent” requirements that create cumulative obstacles and delays in accessing abortion. For example, South Dakota requires

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<sup>72</sup> See Br. of American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, et al., as Amici Curiae in Support of June Medical Services, L.L.C., *June Medical Services, L.L.C. v. Russo*, 140 S. Ct. 2103 (2016) (Nos. 18-1323 & 18-1460), 2019 WL 6609234 at \*7 (citing National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 14 (2018)).

<sup>73</sup> See Corinne H. Rocca et al., *Emotions and Decision Rightness over Five Years Following an Abortion: An Examination of Decision Difficulty and Abortion Stigma*, 248 SOC. SCI. & MED. 112704 (2020); Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95(3) CONTRACEPTION 269 (2017); Jenneke van Ditzhuijzen, *Incidence and Recurrence of Common Mental Disorders After Abortion: Results from a Perspective Cohort Study*, 84 J. PSYCHIATRIC RES. 200 (2017); Diana Greene Foster et al., *Attitudes and Decision Making Among Women Seeking Abortions at One U.S. Clinic*, 44(2) PERSP. ON SEXUAL AND REPROD. HEALTH 117 (2012); Brenda Major et al., *Psychological Responses of Women after First-Trimester Abortion*, 57(8) ARCHIVES OF GENERAL PSYCHIATRY 777 (2000).

<sup>74</sup> Compare 2015 Ark. Acts 1086 (West) (imposing mandatory 48-hour waiting period) with 2019 Ark. Acts 801 (West) (imposing mandatory 72-hour waiting period); 2014 Mo. Legis. Serv. H.B. 1307 & 1313 (West’s No. 136) (increasing mandatory waiting period from 48 hours to 72 hours); 2015 N.C. Sess. Laws 2015-62 (West) (amending N.C. Stat. § 90-21.82(1) to increase mandatory waiting period from 24 to 72 hours); 2015 Okla. Sess. Law ch. 255 (West) (amending Ok. Stat. § 1-738.2(B)(1)(a) to increase mandatory waiting period from 24 to 72 hours); 2011 S.D. Sess. Laws ch. 161 (imposing 72-hour mandatory waiting period); 2013 S.D. Sess. Laws ch. 157 (West) (amending mandatory 72-hour waiting period to exclude weekends and annual state holidays); 2012 Utah Laws ch. 448 (increasing mandatory waiting period from 24 to 72 hours).

<sup>75</sup> See e.g., *Planned Parenthood Minn., N. D., S.D. v. Rounds*, 686 F.3d 889 (8th Cir. 2012) (applying South Dakota law) (upholding law requiring providers to inform patients there is an “increased risk” of suicidal ideation and suicide from abortion, despite lack of medical and scientific evidence); *EMW Women’s Surgical Ctr., P.S.C. v. Beshear*, 920 F.3d 421, 423 (6th Cir. 2019), cert. denied sub nom. *EMW Women’s Surgical Ctr., P.S.C. v. Meier*, 140 S. Ct. 655 (2019) (upholding law requiring physician to make audible fetal heart tones, perform an ultrasound, and display and describe the ultrasound image to the patient); *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 530 F.3d 724 (8th Cir. 2008) (en banc) (upholding law requiring physicians to inform patients that abortion terminates the life of a whole, separate, and unique human being).

<sup>76</sup> See, e.g., N.D. Cent. Code § 14-02.1-02 (West); N.C. Gen. Stats. Ann. § 90-21.82 (West).

<sup>77</sup> Whether a given law of this type violates the constitutional right to abortion can be a “troubling” and “close[]” question that sometimes but not always leads courts to strike down these laws. *Casey*, 505 U.S. at 885-86; *Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014), cert. denied, 135 S. Ct. 2838 (2015) (striking down law requiring physician to make audible fetal heart tones, perform an ultrasound, and display and describe the ultrasound image to the patient); *Adams & Boyle, P.C. v. Slatery*, 494 F. Supp. 3d 488 (M.D. Tenn. 2020) (striking down mandatory 48-hour waiting period for imposing undue burden on access to abortion), stay pend. appeal granted, *Bristol Reg. Women’s Ctr., P.C. v. Slatery*, 994 F.3d 774 (6th Cir. Apr. 23, 2021) (en banc); *Planned Parenthood of Heartland v. Heineman*, 724 F. Supp. 2d 1025 (D. Neb. 2010) (enjoining law requiring abortion providers to evaluate patients for and inform them of numerous “risk factors” prior to providing abortion care). The problem of these laws hindering more than informing the pregnant person’s choice is sufficiently pervasive to warrant a federal remedy.

patients to consult with a CPC prior to receiving an abortion and imposes the longest mandatory waiting period in the nation: 72 hours, excluding holidays and weekends.

Currently, 15 states have requirements that patients undergo a pre-abortion ultrasound regardless of medical necessity, though not all of those requirements are in effect.<sup>78</sup> Five of those states require that the provider display and describe the image under all or most circumstances, regardless of whether such actions will harm the patient.<sup>79</sup>

Thirty-three states require that patients receive counseling before an abortion, with 29 of those states mandating specific information each patient must receive.<sup>80</sup> The information required to be given during counseling varies by state, but often contains biased information and medical inaccuracies, including medically unsound information on the risks of abortion, the mental health consequences of having an abortion, fetal pain, and that a medication abortion can be “reversed.”<sup>81</sup> Twenty-six states require a waiting period, typically 24 hours, between the counseling and the abortion, with 13 of them requiring that the counseling be provided in person, necessitating a second, medically unnecessary trip to an abortion provider.<sup>82</sup> These requirements are not necessary to ensure informed consent, as abortion providers, along with all other medical providers, are already both ethically and legally required to obtain informed consent from patients before rendering services.<sup>83</sup> Further, reliable scientific research indicates that most everyone is certain of

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<sup>78</sup> ALA. CODE § 26-23A-6(b); ARIZ. REV. STAT. § 36-2156(A)(1); ARK. CODE ANN. § 20-16-1303(b); FLA. STAT. § 390.0111(3)(b); IND. CODE ANN. § 16-34-2-1.1(5); IOWA CODE § 146A.1; KAN. ADMIN. REGS. § 28-34-137(b)(3); KY. REV. STAT. § 311.727(2)(a); LA. STAT. ANN. § 40: 1061.10; MISS. CODE ANN. § 41-41-34(1)(a); N.C. GEN. STAT. § 90-21.85; OKLA. STAT. ANN. TIT. 63, § 1-738.3d; TENN. CODE ANN. § 39-15-215(b)(3); TEX. HEALTH & SAFETY CODE § 171.012; WIS. STAT. § 253.10.

<sup>79</sup> *Requirements for Ultrasound*, GUTTMACHER INSTITUTE (May 12, 2021) <https://www.guttmacher.org/state-policy/explore/requirements-ultrasound>. See also *EMW Women's Surgical Ctr., P.S.C. v. Beshear*, 920 F.3d 421, 423 (6th Cir. 2019), *cert. denied sub nom. EMW Women's Surgical Ctr., P.S.C. v. Meier*, 140 S. Ct. 655 (2019) (upholding law requiring physician to make audible fetal heart tones, perform an ultrasound, and display and describe the ultrasound image to the patient); *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012) (upholding statute requiring physician to disclose sonogram and fetal heart tones and explain results of each procedure). *But see Stuart v. Camnitz*, 774 F.3d 238 (4th Cir. 2014), *cert. denied* 135 S. Ct. 2838 (2015) (striking down law requiring physician to make audible fetal heart tones, perform an ultrasound, and display and describe the ultrasound image to the patient).

<sup>80</sup> See *Counseling and Waiting Periods for Abortion*, *supra* note 71; *Evidence You Can Use: Mandatory Counseling for Abortion*, GUTTMACHER INSTITUTE (Jan. 2020) <https://www.guttmacher.org/evidence-you-can-use/mandatory-counseling-abortion>.

<sup>81</sup> See *Evidence You Can Use: Mandatory Counseling for Abortion*, *supra* note 80. See also *Planned Parenthood of Tenn. & North Miss. v. Slatery*, 2021 WL 765606, Case No. 3:20-cv-00740 (M.D. Tenn. Feb. 26, 2021) (issuing a preliminary injunction blocking a law that would require physicians to provide false and misleading information to patients about the potential to “reverse” a medication abortion); *Am. Med. Assn. v. Stenehjem*, 412 F.Supp.3d 1134 (D.N.D. 2019) (issuing a preliminary injunction blocking a law that would require physicians to provide false and misleading information to patients about the potential to “reverse” a medication abortion); Verified Petition, *Tulsa Women's Reproductive Clinic v. Hunter*, Case No. CV-2109-2176 (Okla. Cty. Dist. Ct. Sept. 26, 2019) (issuing a preliminary injunction blocking a law that would require physicians to provide false and misleading information to patients about the potential to “reverse” a medication abortion); *Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048 (D. S.D. 2011) (issuing a preliminary injunction blocking a law that would require physicians to inform patients about “risks” of the procedure that have been rejected by mainstream medicine).

<sup>82</sup> See *Counseling and Waiting Periods for Abortion*, *supra* note 71.

<sup>83</sup> See Brief for Illinois et al. as Amicus Curiae, p. 7, *Bristol Regional Women's Center v. Slatery*, No. 20-6267 (6th Cir. 2021).

their decision at the time of their abortion,<sup>84</sup> and that the overwhelming majority of people having abortions report that it was the right decision within a week after the abortion and five years later.<sup>85</sup>

These laws are harmful because they both impede access to quality care and undermine the ability of pregnant people and their doctors to make decisions based on medically accurate information. Requiring doctors to perform unnecessary services, provide patients with inaccurate medical information, and/or subject patients to mandatory waiting periods increases the cost of care, and can lead to medically unnecessary delays, and the inability to obtain abortion care.<sup>86</sup> This problem is compounded where state laws require patients to make multiple trips to an abortion provider, especially when these two-trip requirements increase the total distance patients must travel to access care.<sup>87</sup> These unnecessary requirements expose patients to protracted delays, unnecessary distress, and potential psychological harm.<sup>88</sup> And two-trip requirements are particularly burdensome on patients with low incomes.<sup>89</sup>

### *iii. Restrictions on Medication Abortion*

Finally, although medication abortion is safe, effective, and in-demand,<sup>90</sup> states frequently impose medically unnecessary restrictions on its provision, limiting patients' access to a method of abortion that has been widely recognized as safe and effective by medical experts and

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<sup>84</sup> Foster, D.G. et al. (2012), *Attitudes and Decision Making Among Women Seeking Abortions at One U.S. Clinic*, Perspectives on Sexual and Reproductive Health, 44(2), 117-124; Ralph, L.J., et al. (2017), *Measuring Decisional Certainty Among Women Seeking Abortion*, Contraception, 95(3), 269-278.

<sup>85</sup> Major, B. et al. (2000), *Psychological Responses of Women after First-Trimester Abortion*. *Archives of General Psychiatry*, 57(8), 777-784; Rocca et al. (2020), *Emotions and Decision Rightness over Five Years Following an Abortion: An Examination of Decision Difficulty and Abortion Stigma*. *Social Science & Medicine*, 248; van Ditzhuijzen, J. et al. (2017), *Incidence and Recurrence of Common Mental Disorders After Abortion*. *Results from a Perspective Cohort Study*, J. Psychiatric Research, 84, 200-206.

<sup>86</sup> See *Counseling and Waiting Periods for Abortion*, *supra* note 71; *Mandatory Counseling for Abortion*, *supra* note 80; THE TEXAS POLICY EVALUATION PROJECT, IMPACT OF ABORTION RESTRICTIONS IN TEXAS: RESEARCH BRIEF (Jan. 2014) <https://tinyurl.com/7p3d587e>; *Adams & Boyle, P.C. v. Slatery*, 494 F. Supp. 3d 488, 501-07 (M.D. Tenn. 2020); Trial Testimony of Caitlin Meyers, Ph.D., Tr. Trans. at 916-1033, *Falls Church Healthcare Center v. Oliver*, Case No. 3:18-cv-428 (E.D. Va. May 23, 2019).

<sup>87</sup> One quarter of the Texas clinics in the study reported a decrease in the number of physicians after the restrictions were put in place due to the difficulty in scheduling. Physician hours increased at most clinics, with an average increase of 8 hours/week. THE TEXAS POLICY EVALUATION PROJECT, *supra* note 86.

<sup>88</sup> Almost one third of women surveyed reported that the waiting period had a negative effect on their emotional well-being. However, the consultation visit and ultrasound viewing did not affect the surveyed women's decision. 92% of surveyed women reported that they were sure of their decision or that abortion was a better choice for them before the consultation visit, and the proportion reporting the same was unchanged following the consultation and ultrasound. *Id.*

<sup>89</sup> Trial Testimony of Jane Collins, Ph.D., Tr. Trans. at 761-841, *Falls Church Healthcare Center v. Oliver*, Case No. 3:18-cv-428 (E.D. Va. May 22, 2019); Decl. of Jane Collins, Ph.D., *Planned Parenthood of Ind. & Ky. v. Comm'r, Ind. State Dept. of Health*, Case No. 1:16-cv-01807 (S.D. Ind. Aug. 1, 2016) (ECF 24-2); Expert Rpt. of Jane Collins, Ph.D., *Planned Parenthood of the Heartland v. Branstad*, Case No. EQCE081503 (Polk Cty. Dist. Ct., Iowa July 19, 2017).

<sup>90</sup> See Br. of American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, et al., as Amici Curiae in Support of June Medical Services, L.L.C., *June Medical Services, L.L.C. v. Russo*, 140 S. Ct. 2103 (2016) (Nos. 18-1323 & 18-1460), 2019 WL 6609234 at \*7 (citing National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 14 (2018)).

organizations worldwide.<sup>91</sup> These laws further reflect the widespread and increasing pattern and practice of states enacting harmful, medically unnecessary, and unconstitutional restrictions that are not supported by credible scientific evidence—and have the purpose and effect of placing undue and substantial obstacles in front of people seeking to obtain an abortion. These laws reflect a focus on impeding access to abortion care at every stage of pregnancy, including D&E (which is the safest and most common method of abortion early in the second trimester, and the standard of care for surgical abortion after 14-15 weeks) and medication abortion (which is currently available only during the first 11 weeks of pregnancy), and the use of increasingly inflammatory rhetoric intended to paint any method of abortion care as jeopardizing the integrity of the medical profession.

Thirty-two states require that medication abortion be provided by a licensed physician, while 19 states require that the prescribing clinician be in the physical presence of the patient during the procedure.<sup>92</sup> These requirements limit health care providers' ability to provide abortion services via telemedicine, an important form of access for people in rural areas or people who cannot easily access a clinic.<sup>93</sup> Access to medication abortion via telemedicine has become even more crucial during the ongoing coronavirus pandemic, which has imposed even more barriers on patients' ability to obtain abortion care in person.<sup>94</sup>

States are increasingly introducing legislation to severely restrict or completely prevent access to medication abortion. In 2021, seven states, Alabama, Iowa, Indiana, Oklahoma, Texas, West Virginia, and Wyoming introduced or enacted legislation that would either ban or impose excessive restrictions on medication abortion.<sup>95</sup> Additionally, nine states introduced legislation

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<sup>91</sup> Medication abortion is a preferred method of abortion in the United States due to its noninvasive nature and flexibility in terms of setting, with medication abortions making up 39% of all abortions in the United States in 2017. *Evidence You Can Use: Medication Abortion*, GUTTMACHER INSTITUTE (Nov. 2019), <https://www.guttmacher.org/evidence-you-can-use/medication-abortion>.

<sup>92</sup> *Medication Abortion*, GUTTMACHER INSTITUTE (June 1, 2021), <https://www.guttmacher.org/state-policy/explore/medication-abortion>.

<sup>93</sup> *Id.*

<sup>94</sup> *FDA v. Am. Coll. of Obstetricians & Gynecologists*, 141 S. Ct. 578, 582 (2021) (Sotomayor, J., dissenting) (“Due to particularly severe health risks, vastly limited clinic options, and the 10-week window for obtaining a medication abortion, the FDA’s requirement that women obtain mifepristone in person during the COVID–19 pandemic places an unnecessary and undue burden on their right to abortion. Pregnancy itself puts a woman at increased risk for severe consequences from COVID–19. In addition, more than half of women who have abortions are women of color, and COVID–19’s mortality rate is three times higher for Black and Hispanic individuals than non-Hispanic White individuals. On top of that, three-quarters of abortion patients have low incomes, making them more likely to rely on public transportation to get to a clinic to pick up their medication. Such patients must bear further risk of exposure while they travel, sometimes for several hours each way, to clinics often located far from their homes.”).

<sup>95</sup> *State Legislation Tracker*, GUTTMACHER INSTITUTE (June 1, 2021) <https://www.guttmacher.org/state-policy>; H.B. 377 (Ala. 2021) <http://alisondb.legislature.state.al.us/ALISON/SearchableInstruments/2021RS/PrintFiles/HB377-int.pdf>; H.B. 331, 89th Gen. Assemb. (Iowa 2021) <https://www.legis.iowa.gov/docs/publications/LGI/89/HF331.pdf>; H.B. 1577, 122nd Gen. Assemb. (Ind. 2021) <http://iga.in.gov/static-documents/6/a/5/1/6a51b440/HB1577.04.ENRS.pdf>; S.B. 779, 59th Leg. (Okla. 2021) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2021-22%20ENR/SB/SB779%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/SB/SB779%20ENR.PDF); S.B. 778, 59th Leg. (Okla. 2021) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2021-22%20ENR/SB/SB778%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/SB/SB778%20ENR.PDF); S.B. 394, 87th Leg. (Tex. 2021) <https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB00394E.pdf#navpanes=0>; S.B. 563, 85th Leg. (W. Va. 2021)

[https://www.wvlegislature.gov/Bill\\_Status/bills\\_text.cfm?billdoc=SB563%20INTR.htm&yr=2021&sesstype=RS&i](https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB563%20INTR.htm&yr=2021&sesstype=RS&i)



prohibiting telemedicine for medication abortion in 2021, with Arizona, Indiana, Montana and Ohio having enacted them.<sup>96</sup> Since 2019, six states, North Dakota, Oklahoma, Tennessee, Indiana, West Virginia, and South Dakota have enacted laws compelling abortion providers to tell patients seeking medication abortion medically inaccurate information about the possibility of medication abortion “reversal.”<sup>97</sup>

It is difficult to explain these laws targeting medication abortion—which are characterized by anti-abortion politicians as modest health and safety regulations—as anything other than the continuation of a long-standing, persistent, widespread, and growing pattern of state legislatures passing laws with the purpose and effect of unduly and substantially burdening the exercise of a constitutional right and the availability of an essential component of comprehensive reproductive health care, at any and all stages of pregnancy. Placing medically unnecessary and rigid restrictions on medication abortions force patients to travel where they otherwise would not need to, and make abortion access more costly, time consuming, and logistically difficult to obtain.<sup>98</sup> Banning and restricting medication abortion, a safe and effective method of ending a pregnancy in the privacy of one’s home makes no sense as a supposed health and safety measure. It is a telling piece of an organized, national, politically-motivated campaign by state governments to reduce or eliminate abortion by strewing obstacles in the path of people seeking medical care and control over their lives and destinies.<sup>99</sup>

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=563; S.B. 595, 85th Leg. (W. Va. 2021)

[http://www.wvlegislature.gov/Bill\\_Status/bills\\_text.cfm?billdoc=SB595%20INTR.htm&yr=2021&sesstype=RS&i=595](http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB595%20INTR.htm&yr=2021&sesstype=RS&i=595); S.B. 133, 66th Leg. (Wy. 2021) <https://wyoleg.gov/2021/Engross/SF0133.pdf>.

<sup>96</sup> *State Legislation Tracker*, GUTTMACHER INSTITUTE (June 1, 2021) <https://www.guttmacher.org/state-policy>; H.B. 2454, 55th Leg. (Ariz. 2021) <https://www.azleg.gov/legtext/55leg/1R/laws/0320.pdf>; S.B. 778, 59th Leg. (Okla. 2021) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2021-22%20ENR/SB/SB778%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/SB/SB778%20ENR.PDF); H.B. 1577, 122nd Gen. Assemb. (Ind. 2021) <http://iga.in.gov/static-documents/6/a/5/1/6a51b440/HB1577.04.ENRS.pdf>; [H.B. 171, 61st Leg. \(Mont. 2021\) https://leg.mt.gov/bills/2021/HB0199/HB0171\\_1.pdf](#). It is worth noting that while States in general have been expanding access to telemedicine as part of an ongoing trend in medicine advancing these telehealth options, the trend for abortion care is the opposite. States have been increasingly placing restrictions on access to telemedicine for abortion care. *See, e.g., Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic*, CTRS. FOR DISEASE CONTROL (Oct. 30, 2020)

<https://www.cdc.gov/mmwr/volumes/69/wr/mm6943a3.htm> (discussing increase in telehealth access during the COVID-19 pandemic); *Medication Abortion*, GUTTMACHER INSTITUTE (May 2021)

<https://www.guttmacher.org/state-policy/explore/medication-abortion/> (discussing restrictions on medication abortion, including a list of states requiring that the prescribing clinician must be in the physical presence of the patient).

<sup>97</sup> H.B. 1577, 122nd Gen. Assemb. (Ind. 2021) <http://iga.in.gov/static-documents/6/a/5/1/6a51b440/HB1577.04.ENRS.pdf>; S.B. 2196, 111th Gen. Assemb. (Tenn. 2020)

<https://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=SB2196&GA=111>; S.B. 614, 57th Leg. (Okla. 2019) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2019-20%20ENR/SB/SB614%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENR/SB/SB614%20ENR.PDF); S.B. 779, 59th Leg. (Okla. 2021) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2021-22%20ENR/SB/SB779%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/SB/SB779%20ENR.PDF); S.B. 778, 59th Leg. (Okla. 2021) [http://webserver1.lsb.state.ok.us/cf\\_pdf/2021-22%20ENR/SB/SB778%20ENR.PDF](http://webserver1.lsb.state.ok.us/cf_pdf/2021-22%20ENR/SB/SB778%20ENR.PDF); H.B. 1336, 66th Leg. (N.D. 2019) <https://www.legis.nd.gov/assembly/66-2019/documents/19-0517-03000.pdf>; H.B. 2982, 85th Leg. (W. Va. 2021)

[https://www.wvlegislature.gov/Bill\\_Text\\_HTML/2021\\_SESSIONS/RS/bills/HB2982%20INTR.pdf](https://www.wvlegislature.gov/Bill_Text_HTML/2021_SESSIONS/RS/bills/HB2982%20INTR.pdf).

<sup>98</sup> *Evidence You Can Use: Medication Abortion*, GUTTMACHER INSTITUTE (Nov. 2019) <https://www.guttmacher.org/evidence-you-can-use/medication-abortion>.

<sup>99</sup> Olga Khazan, *Planning the End of Abortion*, THE ATLANTIC (July 16, 2015)

<https://www.theatlantic.com/politics/archive/2015/07/what-pro-life-activists-really-want/398297/>; *cf. Norton v. Ashcroft*, 298 F.3d 547, 555 (6th Cir. 2002) (upholding FACE as exercise of Congress’s Commerce Clause authority



### III. Litigation Alone is Insufficient to Preserve Access to Abortion Care

In recent years, these attacks on abortion access have grown by staggering numbers, and piecemeal litigation alone is not sufficient to prevent the harm they cause. The abortion landscape has become increasingly hostile in recent years. Between January 1, 2011 and July 1, 2019, states across the country enacted 483 abortion restrictions, accounting for nearly 40% of all abortion restrictions enacted by states since *Roe* was decided in 1973.<sup>100</sup> In 2020—amidst a global pandemic—states enacted an additional 27 abortion restrictions.<sup>101</sup> And state abortion restrictions have become even more pervasive in 2021, as medication abortion restrictions and bans, as well as anti-abortion state constitutional amendments, introduced in state legislatures have tripled as compared to the same time in 2019.<sup>102</sup> In fact, 2021 is currently on track to be the worst legislative year on record for abortion restrictions.<sup>103</sup> As of June 7th, 2021, 83 additional abortion restrictions have been enacted.<sup>104</sup>

The systematic, sustained effort by state politicians to chip away at abortion access incrementally, restriction-by-restriction, has now reached a crisis point. As a result of the outsized efforts of state lawmakers to undermine and eliminate abortion access, there has been a drastic reduction in the availability of health care services across vast swaths of our country. Today, nearly 90 percent of American counties are without a single abortion provider,<sup>105</sup> and six states are down to their last abortion clinic.<sup>106</sup> More than 27 cities across the country are “abortion deserts,” where patients must travel 100 miles or more to reach an abortion facility.<sup>107</sup>

With hundreds of bans and restrictions being enacted nationwide, and the Supreme Court having agreed to consider a direct challenge to *Roe v. Wade*, it is impossible to adequately ensure that all pregnant people have equal and adequate access to abortion care through litigation alone. The constitutional framework around abortion restrictions relies on an “undue burden” standard that requires state-by-state litigation.<sup>108</sup> For example, even though the Seventh Circuit struck an Indiana

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because disruption of commercial abortion services “was driven by a nationally unified and nationally coordinated anti-abortion movement”).

<sup>100</sup> *State Facts About Abortion: California*, GUTTMACHER INSTITUTE (Jan. 2021), <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-california>.

<sup>101</sup> *State Policy Trends 2020*, *supra* note 28.

<sup>102</sup> *State Abortion Restriction Trend Report*, PLANNED PARENTHOOD FEDERATION OF AMERICA (March 2021), [https://www.plannedparenthood.org/uploads/filer\\_public/18/d7/18d7c70a-a4f6-4498-bdfb-fdbeece3fd6/2021\\_state\\_abortion\\_restriction\\_trend\\_report\\_final.pdf](https://www.plannedparenthood.org/uploads/filer_public/18/d7/18d7c70a-a4f6-4498-bdfb-fdbeece3fd6/2021_state_abortion_restriction_trend_report_final.pdf).

<sup>103</sup> Nash, *2021 is on Track to Become the Most Devastating Antiabortion State Legislative Session in Decades*, *supra* note 7.

<sup>104</sup> *Id.*

<sup>105</sup> GUTTMACHER INSTITUTE, *Data Center: Number of clinics providing abortion by state*, <https://data.guttmacher.org/states> (last visited Feb. 9, 2020).

<sup>106</sup> Holly Yan, *These 6 States Have Only 1 Abortion Clinic Left*, CNN (May 29, 2019), <https://www.cnn.com/2019/05/29/health/six-states-with-1-abortion-clinic-map-trnd/index.html>.

<sup>107</sup> Alice F. Cartwright et al., *Identifying National Availability Of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20(5) J MED INTERNET RES e186 (2018), <https://www.jmir.org/2018/5/e186/>.

<sup>108</sup> See *Casey*, 505 U.S. at 877-78; *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (finding that, in applying the substantial burden test, courts must weigh the extent to which the laws in question actually serve the stated government interest against the burden they impose).

reason ban,<sup>109</sup> the Sixth Circuit recently upheld a nearly identical ban from Ohio.<sup>110</sup> Though many abortion restrictions follow similar patterns and may even have identical language, with hundreds of restrictions enacted throughout the country, there will always be new and distinct restrictions to consider. Relying on litigation for each of these restrictions is inefficient and ineffective, causing uncertainty for patients and their providers. For example, the only remaining abortion providers in Missouri and Kentucky have each had to file lawsuits recently simply to avoid losing their facility licenses.<sup>111</sup> These situations are all too familiar in states hostile to abortion, where providers struggle to operate under the constant barrage of new state regulations while being under siege by state regulators who zealously and disproportionately enforce complicated TRAP laws against abortion providers that do not apply to other comparable medical providers. It is simply unsustainable for abortion providers to continue operating under such conditions, as evidenced by the high number of clinic closures in states hostile to abortion.<sup>112</sup> Litigation is time- and resource-consuming and cannot keep pace with hostile legislation. Many restrictions that are materially similar to ones struck down as unconstitutional remain on the books and continue to be replicated across the country.

#### A. States Are Undeterred by Courts, and Emboldened to Pass Unconstitutional Laws

Even where laws with identical language restricting abortion have previously been struck down by the courts, states are not deterred from enacting restrictions or bans. In its 2016 decision in *Whole Woman's Health*, the Supreme Court struck down two restrictions in a Texas law: an admitting privileges provision requiring all abortion providers to obtain local hospital admitting privileges, and an ambulatory surgical center provision requiring every licensed abortion facility to meet hospital-like building standards.<sup>113</sup> Despite the Supreme Court expressly invalidating those provisions, Louisiana was undeterred and unsuccessfully appealed up to the Supreme Court its defense of an identical admitting privileges law. After years of litigation, the Supreme Court

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<sup>109</sup> *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 888 F.3d 300, 303 (7th Cir. 2018).

<sup>110</sup> *Preterm Cleveland v. McCloud*, No. 18-3329 (6th Cir. 2021).

<sup>111</sup> *Reproductive Health Svs. of Planned Parenthood of the St. Louis Reg. v. Parson*, No. 1922-CC02395, Mo. Admin. Hearing Comm'n (2020) [https://www.plannedparenthood.org/uploads/filer\\_public/98/18/9818b15d-4ecd-4281-bb30-620c5ea9e567/19-0879.pdf](https://www.plannedparenthood.org/uploads/filer_public/98/18/9818b15d-4ecd-4281-bb30-620c5ea9e567/19-0879.pdf) (Missouri Administrative Commission decision finding that the Department of Health and Senior Services wrongfully denied a license renewal for a Planned Parenthood clinic in 2019); *EMW Women's Surgical Ctr., P.S.C. v. Glisson*, 2018 WL 644391 (W.D. Ken. Sept. 28, 2018) (enjoining Kentucky regulatory requirements that abortion facilities maintain transfer and ambulance transport agreements and detailing extensive history of licensure disputes); *Planned Parenthood of Kansas and Mid-Missouri, Inc. v. Lyskowski*, No. 2:15-cv-04273, 2016 WL 2745873 (W.D. Mo. May 11, 2016) (enjoining Missouri Department of Health and Senior Services from revoking Planned Parenthood's facility license and detailing history of disparate treatment); see also Kurt Erickson, 'It was unbearable': Inspectors seemed to be on a mission to close clinic, *Planned Parenthood official testifies*, ST. LOUIS DISPATCH (Nov. 1, 2019), [https://www.stltoday.com/news/local/govt-and-politics/it-was-unbearable-inspectors-seemed-to-be-on-a-mission-to-close-clinic-planned-parenthood/article\\_61f9d04f-1870-5992-9774-27d83541818f.html](https://www.stltoday.com/news/local/govt-and-politics/it-was-unbearable-inspectors-seemed-to-be-on-a-mission-to-close-clinic-planned-parenthood/article_61f9d04f-1870-5992-9774-27d83541818f.html); Kurt Erickson, *Missouri governor won't appeal ruling favoring abortion provider*, St. Louis Dispatch (June 29, 2020), [https://www.stltoday.com/news/local/crime-and-courts/missouri-governor-won-t-appeal-ruling-favoring-abortion-provider/article\\_308d6949-f232-5aad-af42-a3c1222acb39.html](https://www.stltoday.com/news/local/crime-and-courts/missouri-governor-won-t-appeal-ruling-favoring-abortion-provider/article_308d6949-f232-5aad-af42-a3c1222acb39.html).

<sup>112</sup> See Sarah Raifman et al., *Border-state Abortions Increased for Texas Residents after House Bill 2*, CONTRACEPTION (Mar. 21, 2021) <https://www.sciencedirect.com/science/article/abs/pii/S0010782421000895>.

<sup>113</sup> See *Whole Woman's Health*, 136 S. Ct. 2292.

affirmed that Louisiana’s law was unconstitutional in its 2020 decision in *June Medical Services LLC v. Russo*.<sup>114</sup>

Mississippi’s relentless passage of unconstitutional abortion bans is similar. In 2020, the Fifth Circuit struck down a 2019 Mississippi law criminalizing an abortion performed after a “fetal heartbeat has been detected,” a medically inaccurate description used by the state to prohibit abortions as early as 6 weeks into pregnancy.<sup>115</sup> Notably, Mississippi enacted this law *after* the Fifth Circuit confirmed that Mississippi’s 2018 law prohibiting abortions after 15 weeks was an unconstitutional ban on abortion prior to viability.<sup>116</sup>

States hostile to abortion rights are continuing their long-employed strategy of enacting restrictions designed to chip away at abortion access, while also pushing for outright abortion bans. Indeed, many anti-abortion politicians have expressly admitted that their aim is to reduce or eliminate abortion, even while continuing to defend these laws in court as protecting women.<sup>117</sup> This strategy and the new wave of abortion bans have made it clear that states are seeking to directly challenge and overturn long-standing constitutional abortion protections.<sup>118</sup> The district court judge striking down Mississippi’s 15-week ban acknowledged this campaign, stating “the State chose to pass a

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<sup>114</sup> See *June Med.*, 140 S. Ct. 2103.

<sup>115</sup> *Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246 (5th Cir. 2020) (affirming preliminary injunction of 6-week ban).

<sup>116</sup> *Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246 (5th Cir. 2020) (striking down 15-week abortion ban), *cert. granted*, No. 19-1392 (U.S. May 17, 2021).

<sup>117</sup> Compare 2012 Miss. Laws ch. 1331 (H.B. 1390) (West) (requiring all physicians providing abortion to have admitting privileges at local hospital) with Elizabeth Waibel, Reeves: ‘Very Close to Ending Abortion in Miss.’, Jackson Free Press (Mar. 28, 2012) (quoting then-Lt. Gov. Tate Reeves as saying, “We are very close to ending abortion in Mississippi, and I support all the pro-life bills that will do just that, particularly House Bill 1390 that should effectively close the only abortion clinic in Mississippi.”). Compare Alan Blinder, *Louisiana Moves to Ban Abortions After a Heartbeat Is Detected*, New York Times (May 29, 2019), <https://www.nytimes.com/2019/05/29/us/louisiana-abortion-heartbeat-bill.html> (“God values human life, and so do the people of Louisiana,” the state senator, John Milkovich, said this month. “We believe this is an important step in dismantling the attack of the abortion cartel on our next generation.”) with Br. of Respondent in Opposition to Certiorari at 2, *June Med. Servs., L.L.C. v. Gee*, Case No. 18-1323 (U.S. June 19, 2019) (arguing Louisiana’s admitting privileges law protects patients from abortion providers’ alleged “indifference to doctor qualifications and the threat that indifference poses to women.”), and *June Med. Servs. v. Russo*, 140 S. Ct. 2130 (2020) (striking down the admitting privileges requirement as imposing undue burden on the right to abortion, finding it offered no significant health-related benefits). See *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 995-96 (W.D. Wis. 2015), *aff’d sub nom. Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015) (concluding that the admitting privileges “legislation was motivated by an improper purpose, namely to restrict the availability of abortion services in Wisconsin.”). See generally Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 Duke L. J. 1641 (2008).

<sup>118</sup> Recording of Oral Argument at 9:15, *Memphis Ctr. for Reproductive Health v. Slatery*, Case No. 20-5969 (6th Cir. Apr. 29, 2021), available at [https://www.opn.ca6.uscourts.gov/internet/court\\_audio/aud2.php?link=recent/04-29-2021%20-%20Thursday/20-5969%20Memphis%20Ctr%20for%20Repro%20Health%20et%20al%20v%20Herbert%20Slatery%20III%20et%20al.mp3&name=20-5969%20Memphis%20Ctr%20for%20Repro%20Health%20et%20al%20v%20Herbert%20Slatery%20III%20et%20al](https://www.opn.ca6.uscourts.gov/internet/court_audio/aud2.php?link=recent/04-29-2021%20-%20Thursday/20-5969%20Memphis%20Ctr%20for%20Repro%20Health%20et%20al%20v%20Herbert%20Slatery%20III%20et%20al.mp3&name=20-5969%20Memphis%20Ctr%20for%20Repro%20Health%20et%20al%20v%20Herbert%20Slatery%20III%20et%20al).

law it knew was unconstitutional to endorse a decades-long campaign, fueled by national interest groups, to ask the Supreme Court to overturn *Roe v. Wade*.”<sup>119</sup>

## B. Even Where Restrictions Are Struck Down, It Can Be Impossible to Restore Access

As states continuously enact unconstitutional restrictions and bans, abortion providers and their patients bear the brunt of the consequences of protracted litigation, even where harmful provisions are ultimately struck down.

The proliferation of restrictions, and their changing status as blocked or unblocked during different phases of litigation, causes confusion and disruption for providers and patients alike. For example, when Texas Attorney General Ken Paxton banned procedures he deemed “medically unnecessary” during the coronavirus pandemic in March 2020, including abortion, litigation caused the ban to be lifted and reinstated multiple times, forcing providers to cancel appointments with little to no notice.<sup>120</sup> Evidence suggests that the mere passage of restrictive legislation leads some people to believe that abortion is illegal in their state, even when the restrictions never go into effect, which could cause people to delay accessing abortion care.<sup>121</sup>

The direct effect of these types of abortion restrictions and bans is that they delay access to care, increase costs for patients, and burden providers to the extent that they are forced to reduce or stop providing abortion care or close clinics altogether. And once a clinic closes, it is very difficult—if not impossible—for it to reopen. For example, in 2011, Texas excluded Planned Parenthood clinics from family planning reimbursements and in 2013, the state enacted H.B. 2, an omnibus abortion bill containing multiple clinic closure laws. Between 2012 and 2014, more than half of the 42 abortion providers in Texas closed.<sup>122</sup> By the end of 2019—more than three years after the Supreme Court struck down the restrictions in H.B.2, there still were just 22 clinics offering abortion care in the state.<sup>123</sup>

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<sup>119</sup> *Jackson Women’s Health Org. v. Currier*, 349 F. Supp. 3d 536, 539 (S.D. Miss. 2018) (citing Arielle Dreher, *Reversing ‘Roe’; Outside Group Uses Mississippi as ‘Bait’ to End Abortion*, JACKSON FREE PRESS, March 14, 2018; Sybil Shainwald, *Reproductive Injustice in the New Millennium*, 20 WM. & MARY J. WOM. & L. 123, 124 (2013)).

<sup>120</sup> Caroline Kitchener, *One Day Abortion is Legal, the Next Day It’s Not: Coronavirus Sparks a Ping-Pong Fight in Texas*, THE LILY (Apr. 21, 2020), <https://www.thelily.com/one-day-abortion-is-legal-the-next-day-its-not-coronavirus-sparks-a-ping-pong-fight-in-texas/>.

<sup>121</sup> See Maria F. Gallo et al., *Passage of Abortion Ban and Women’s Accurate Understanding of Abortion Legality*, AM. J. OBSTETRICS & GYNECOLOGY (2021), <https://doi.org/10.1016/j.ajog.2021.02.009> (finding an increase, from 4.5% to 15.9%, in the fraction of women who mistakenly believed that abortion is illegal in Ohio in the eight month period in which a 6-week ban on abortion was passed by the state legislature, signed into law, and subsequently enjoined by the courts before ever being enacted); Anna North, *Abortion is Still Legal in America*, VOX (May 16, 2019), <https://www.vox.com/2019/5/16/18626744/alabama-abortion-law-legal-50-states-roe> (discussing how strict anti-abortion laws throughout the country make patients believe that abortion has been outlawed).

<sup>122</sup> Danielle Paquette, *After Planned Parenthood closures, poor women started having more babies*, Washington Post (Feb. 5, 2016) <https://www.washingtonpost.com/news/wonk/wp/2016/02/05/after-planned-parenthood-closures-poor-women-started-having-more-babies/>.

<sup>123</sup> See Ashley Lopez, *supra* note 6; Grossman, *supra* note 6 (finding that, in the year following the implementation of Texas’ abortion restrictions, the number of facilities providing abortion services in Texas declined by 46%).

When state laws result in clinic closures, communities also lose additional critical health care services that may have been provided at that clinic, such as contraceptive care and screenings for cervical and breast cancer and sexually transmitted infections. This risk is especially high in states that impose multiple layers of restrictions that single out abortion providers and treat them differently than medical practices providing comparable care. For example, in 2016, the *New England Journal of Medicine* assessed rates of contraceptive-method provision, method continuation through the program, and childbirth covered by Medicaid before and after the Planned Parenthood exclusion and subsequent passage of H.B. 2.<sup>124</sup> The study found that “after Texas abruptly excluded Planned Parenthood affiliates from its fee-for-service family-planning program, the number of claims for [Long-Acting Reversible Contraception] methods declined, as did the number of claims for contraceptive injections. Among women using injectable contraceptives, fewer women who received an injection in the quarter preceding the exclusion continued to receive an injection through the program than did those in an earlier cohort.”<sup>125</sup>

Even where clinics have managed to stay open in the face of restrictions, many have struggled to provide care. For example, other clinics in the area closing may put a strain on a remaining clinic without the resources to keep up with higher demand for its services.<sup>126</sup> Additionally, restrictions on certain types of services, like medication abortion, or requiring medically unnecessary services or counseling, may require more physician hours and expenditures in order to provide care for the same number of patients.<sup>127</sup>

Clinic closure also leads to overcrowding at remaining providers. A 2019 study reviewing the impact of Texas’ H.B. 2, determined that this law resulting in the closure of half of the state’s abortion facilities created provider shortages that delayed Texas women in their efforts to access abortion care.<sup>128</sup> These findings show that restrictive abortion laws reduce women’s access to care and unnecessarily delay their abortion care.<sup>129</sup> This delay has two consequences. Some patients are prevented from accessing abortion care at all.<sup>130</sup> For patients that are still able to access care, delay can increase the costs of the procedure and force patients to obtain abortion later in pregnancy which, while extremely safe, poses increased health risks and is more costly and burdensome.<sup>131</sup>

#### **IV. Abortion Restrictions Harm Patients and Perpetuate Systemic Barriers to Health Care that Disproportionately Burden Black, Indigenous, and People of Color.**

Bans and restrictions on abortion interfere with people’s liberty and equality by putting access to essential health care out of reach. They impose logistical and financial burdens on patients, as a

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<sup>124</sup> Amanda J. Stevenson et al, *Effect of Removal of Planned Parenthood from the Texas Women’s Health Program*, *N. Engl. J. Med.* 2016; 374:853-860, <https://www.nejm.org/doi/full/10.1056/NEJMsa1511902>.

<sup>125</sup> *Id.*

<sup>126</sup> Michelle L. McGowan et al., *Care Churn—Why Keeping Clinic Doors Open Isn’t Enough to Ensure Access to Abortion*, 383(6) *N. ENGL. J. MED.* 508 (2020).

<sup>127</sup> *Id.*

<sup>128</sup> White K, Baum S, Hopkins K, Potter JE, and Grossman D. Change in second-trimester abortion after implementation of a restrictive state law. *Obstetrics & Gynecology* 2019; 133(4):771-779.

<sup>129</sup> *Id.*

<sup>130</sup> Advancing New Standards in Reproductive Health, *Turnaway Study: Long-Term Study Shows that Restricting Abortion Harms Women*, BIXBY CENTER FOR GLOBAL REPRODUCTIVE HEALTH (retrieved from [https://www.ansirh.org/sites/default/files/publications/files/turnaway\\_study\\_brief\\_web.pdf](https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf)).

<sup>131</sup> *June Med.*, 140 S. Ct at 2128-30.



person seeking care must often take extra time away from work and find and pay for additional childcare, transportation, and lodging.<sup>132</sup>

These burdens fall most heavily on those already facing systemic barriers to health care, as well as other social, political, and environmental inequities. People with low incomes, Black, Indigenous, and People of Color (BIPOC), young people, immigrants, people with disabilities, people who live in rural communities and other medically underserved areas, and LGBTQ+ people experience significant barriers to accessing quality health care that are then further compounded by bans and restrictions on abortion care. For example, according to the U.S. Department of Health and Human Services (HHS) Healthy People 2020 Initiatives, “LGBT individuals face health disparities related to societal stigma, discrimination, and denial of their civil and human rights.”<sup>133</sup> Many people additionally experience discrimination due to multiple, intersecting identities (for instance, low-income people of color who are also transgender or disabled) that compound and intensify barriers to accessing abortion care. For example, as reported in a recent issue brief by the National Partnership of Women and Families and In Our Own Voice: National Black Women’s Reproductive Justice Agenda, Black women are more likely to be exposed to negative social determinants of health; they experience higher rates of poverty, homelessness and housing insecurity, food insecurity and unreliable transportation<sup>134</sup>—all factors that are at least partially responsible for racial disparities in birth outcomes.<sup>135</sup>

Further, being denied an abortion can have serious consequences for a woman’s health and well-being, and that of her family. According to a recent longitudinal study, a woman denied abortion care is at increased risk of experiencing poverty, physical health impairments, and intimate partner violence.<sup>136</sup> Patients denied a wanted abortion are more likely to struggle to pay for basic family needs like food and housing, and their children are more likely to live below the federal poverty line.<sup>137</sup> Removing medically unnecessary restrictions and bans on abortion is a critical step towards ensuring the full range of reproductive health care, including abortion care, is truly accessible for all who need it.

In order for abortion care to be truly accessible it must not be conditioned by a person’s economic circumstances, status, or identity. The restrictions addressed by the Women’s Health Protection Act increase barriers and burdens and perpetuate systematic disparities and inequities. Abortion

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<sup>132</sup> To cover these costs, low-income patients may be forced to forgo basic necessities, like food and rent, or borrow money. Rachel K. Jones et al., *At What Cost? Payment for Abortion Care by U.S. Women*, 23(3) WOMEN’S HEALTH ISSUES e173-178 (2013), available at <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.whi.2013.03.001.pdf>.

<sup>133</sup> U.S. DEPT. OF HEALTH & HUMAN SERVS, *LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH*, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last visited Feb. 9, 2020).

<sup>134</sup> NAT’L PARTNERSHIP FOR WOMEN & FAMILIES & IN OUR OWN VOICE: NAT’L BLACK WOMEN’S REPRODUCTIVE JUSTICE AGENDA, *Maternal Health And Abortion Restrictions: How Lack Of Access To Quality Care Is Harming Black Women* (Oct. 2019), <https://www.nationalpartnership.org/our-work/resources/repro/maternal-health-and-abortion.pdf>.

<sup>135</sup> *Id.*

<sup>136</sup> Diana Greene Foster et al., *Socioeconomic outcomes of women who receive and women who are denied wanted abortions*, 108(3) AM. J. PUB. HEALTH 407-413 (2018); *Turnaway Study*, *supra* note 130.

<sup>137</sup> Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term*, 205 J. PEDIATRICS 183-189 (2019), [https://www.jpeds.com/article/S0022-3476\(18\)31297-6/fulltext](https://www.jpeds.com/article/S0022-3476(18)31297-6/fulltext).

restrictions have tremendously harmful impacts on communities subjected to discrimination and oppression and are inimical to reproductive health, rights, and justice. In addition, limitations on insurance coverage of abortion continue to severely limit abortion access, especially for low-income people and others who receive their health coverage or care through the federal government. The Women’s Health Protection Act does not fix all these problems, but works hand-in-hand with bills such as the Equal Access to Abortion Coverage in Health Insurance (EACH) Act, a federal bill to eliminate federal coverage restrictions on abortion care, including the Hyde Amendment’s ban on coverage for Medicaid enrollees.<sup>138</sup> Together, the Women’s Health Protection Act and the EACH Act have the power to significantly improve abortion access across the country—bringing us closer to a world in which all people can exercise their constitutional rights and the real ability to access abortion services, no matter their state of residence, their income, or their health insurance coverage plan.

## **V. U.S. Anti-Abortion Laws Are Out of Alignment with the Overwhelming Global Trend Towards Liberalization of Abortion.**

In the past twenty-five years, 56 countries have liberalized their abortion laws, including 20 countries that have removed complete abortion bans.<sup>139</sup> Examples include New Zealand, which reformed its law to allow abortion up to 20 weeks gestation and remove the regulation of abortion from its penal code; Iceland, which legalized abortion on request through 22 weeks of pregnancy, and later in pregnancy where a women’s health or life is at risk; and South Korea, whose Constitutional Court struck down the country’s restrictive abortion law for violating the right to self-determination, thereby decriminalizing abortion. Other jurisdictions liberalizing their abortion laws in recent years include New South Wales, Australia, which removed abortion from the criminal code and now permits abortion up to 22 weeks gestation; Argentina, which broadly legalized abortion where it had previously been permitted only in cases of rape, incest, or when a woman’s life is in danger; Ireland, which dramatically repealed its constitutional prohibition on abortion through a national referendum, bringing the country into compliance with the rulings of the United Nations Human Rights Committee in the *Mellet v. Ireland* (2016) and *Whelan v. Ireland* (2017), cases brought by the Center for Reproductive Rights; and Rwanda, which enacted reforms to ensure that abortion on health grounds included protections for social and mental, as well as physical wellbeing.

Other jurisdictions have recently expanded access to abortion by ensuring that abortion care is covered by national public health systems. Nepal recently enacted legislation that requires governments at all levels to ensure that funding is available to fulfill the government’s earlier mandate for free abortion care in public health facilities. In Ireland, where abortion was recently legalized, abortion is available free through the public health service for people who live in Ireland.

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<sup>138</sup> EACH Act of 2021, S. 1021, 117th Cong. (2021) <https://www.congress.gov/bill/117th-congress/senate-bill/1021?q=%7B%22search%22%3A%5B%22Equal+Access+to+Abortion+Coverage+in+Health+Insurance%22%5D%7D&s=1&r=1>.

<sup>139</sup> The World’s Abortion Laws, CENTER FOR REPRODUCTIVE RIGHTS, <https://reproductiverights.org/worldabortionlaws>.

A notable exception to the trend of abortion liberalization in Europe is Poland, where a recent court ruling has ended almost all legal abortion in Poland.<sup>140</sup> This ruling has been strongly condemned by the European Parliament,<sup>141</sup> the Committee of Ministers of the Council of Europe,<sup>142</sup> and UN human rights experts.<sup>143</sup>

Further, international human rights law increasingly recognizes and protects access to safe and legal abortion as central to women's autonomy and reproductive health, and to achieving gender equality.<sup>144</sup> International human rights norms also require that, where abortion is legal, government must ensure that it is genuinely available and accessible in practice.<sup>145</sup> Treaty bodies have condemned procedural barriers to abortion services, including mandatory waiting periods, biased counseling, and requirements that a third party, such as a male guardian or a parent, authorize the abortion.<sup>146</sup>

The International Covenant on Civil and Political Rights (ICCPR), which the United States ratified in 1992, contains particularly important protections for access to abortion. In 2016 and 2017, in two decisions that contributed to law reform in Ireland, the UN Human Rights Committee, which oversees implementation of the ICCPR, found that Ireland's prohibition and criminalization of abortion violated the rights to be free from cruel, inhuman, or degrading treatment, to privacy, and to equality before the law by prohibiting two women from obtaining abortion care in their own country and forcing them to travel to a foreign jurisdiction to access abortion care.<sup>147</sup> Moreover, in 2018, the UN Human Rights Committee made clear that the right to life enshrined in Article 6 of the ICCPR includes the right to access safe and legal abortion without the imposition of restrictions which subject women and girls to physical or mental pain or suffering, discriminate against them, arbitrarily interfere with their privacy, or place them at risk of undertaking unsafe

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<sup>140</sup> Const'l Tribunal Act K / 120, 22 X 2020, Family planning, the protection of foetuses, and grounds for permitting the termination of a pregnancy (Pol.).

<sup>141</sup> European Parliament Press Release, *Polish De Facto Ban on Abortion Puts Women's Lives at Risk, says Parliament* (Nov. 26, 2020), <https://www.europarl.europa.eu/news/en/press-room/20201120IPR92132/polish-de-facto-ban-on-abortion-puts-women-s-lives-at-risk-says-parliament>.

<sup>142</sup> Committee of Ministers, *Interim Resolution CM/ResDH(2021)44*, 11 March 2021 available at: [https://search.coe.int/cm/Pages/result\\_details.aspx?ObjectID=0900001680a1bdc4](https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=0900001680a1bdc4).

<sup>143</sup> *Poland Has Slammed Door Shut on Legal and Safe Abortions-UN Experts*, UN HUMAN RIGHTS (Oct. 27, 2020) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26434&LangID=E>.

<sup>144</sup> For example, in 2018, the U.N. Human Rights Council reaffirmed the global consensus that ensuring reproductive health and safety, including access to abortion, is of the utmost importance under international law. Human Rights Council Res. on the Elimination of All Forms of Discrimination against Women and Girls, U.N. Doc. A/HRC/38/L.1/Rev.1, at 3 (July 3, 2018).

<sup>145</sup> In *L.M.R. v. Argentina*, the U.N. Human Rights Committee determined that the ICCPR was violated when a woman was denied access to a legal abortion—and was forced to arrange a clandestine abortion—due to the refusal of hospital staff to perform the procedure. Human Rights Committee, Communication No. 1608/2007, ¶¶ 9.2–9.4, U.N. Doc. CCPR/C/101/D/1608/2007 (2011). Similarly, the European Court of Human Rights has condemned Poland for erecting “significant barriers” to reproductive health services “in practice.” *P. and S. v. Poland*, No. 57375/08, Eur. Ct. H.R. (2012).

<sup>146</sup> Center for Reproductive Rights, *Breaking Ground: Treaty Monitoring Bodies on Reproductive Rights*, at 19 (2019), <https://reproductiverights.org/sites/default/files/documents/Breaking-Ground-2020.pdf>.

<sup>147</sup> See *Siobhán Whelan v. Ireland*, Human Rights Committee, Commc'n No. 2425/2014, para.8, U.N. Doc. CCPR/C/119/D/2425/2014 (2017); *Amanda Jane Mellet v. Ireland*, Human Rights Committee, Commc'n No. 2324/2013, para. 8, U.N. Doc. CCPR/C/116/D/2324/2013 (2016).

abortions.<sup>148</sup> The Committee stated that at a minimum the right to life requires states parties to provide safe, legal, and effective access to abortion where either the life and the health of the pregnant woman or girl is at risk, or when carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering.<sup>149</sup> The Committee stated that treaty parties should not introduce new barriers to abortion and should remove existing barriers that deny effective access by women and girls to safe and legal abortion.<sup>150</sup> And it stated that parties to the ICCPR should likewise prevent the stigmatization of women and girls seeking abortion.<sup>151</sup>

The UN human rights treaty monitoring bodies have also made clear that countries cannot roll back rights once they have been established. A core human rights principle prohibits retrogression, which is a backwards step in law or policy that impedes or restricts the enjoyment of a right. The Committee on Economic, Social and Cultural Rights has particularly noted the importance of avoiding retrogressive measures in the area of sexual and reproductive health and rights, including the imposition of barriers to sexual and reproductive health information, goods, and services.<sup>152</sup>

Those who argue that United States' abortion laws are out of step with other countries simplistically and misleadingly draw comparisons of U.S. gestational limits to those in place in other countries. This faulty comparative analysis focuses on countries with profoundly different legal traditions than the United States and fails to analyze the full legal and social systems in which abortion laws operate and the ways in which the statutes are applied in practice.<sup>153</sup> For example, many countries that ban abortion outright often do so based entirely on religious grounds, an approach that is fundamentally inconsistent with the American legal tradition.<sup>154</sup> And many countries with gestational limit restrictions simultaneously allow for broad exceptions, including for economic or social circumstances and physical or mental health, thus allowing for abortion later in pregnancy.<sup>155</sup>

It is a myth that retrogression in U.S. abortion law would align the U.S. with the rest of the world. Global liberalization of abortion laws, sound and appropriate comparative law analysis, and international law developments disprove this claim.<sup>156</sup> Rather, the wave of bans and restrictions promulgated by state governments in the U.S. are woefully out of step with human rights law,

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<sup>148</sup> Human Rights Committee, *Gen. Comment 36: on the Right to Life (Art. 6 of the International Covenant on Civil and Political Rights)*, para. 8, U.N. Doc. CCPR/C/GC/36 (Oct. 30, 2018).

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> ESCR Committee, Gen. Comment No. 22: on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), para. 38, U.N. Doc. E/C.12/GC/22 (2016).

<sup>153</sup> See Brief of Amici International and Comparative Law Scholars, *Whole Woman's Health v. Paxton*, No. 17-51060 (5th Cir. Jan. 11, 2021).

<sup>154</sup> *Id.* at 16-18. It should be noted that the consequences of any government's efforts to ban abortion are dire, as exemplified by El Salvador, which has a total ban on abortion and imposes harsh criminal penalties on both women and physicians. The country's abortion ban has resulted in the unjust imprisonment of countless women who have suffered pregnancy-related complications and miscarriages and have been charged with having an abortion and convicted of homicide. See *Case of Manuela v. El Salvador: The Impact of Blanket Abortion Bans on Women Experiencing Obstetric Emergencies*, CENTER FOR REPRODUCTIVE RIGHTS (Mar. 2021) [https://reproductiverights.org/wp-content/uploads/2021/03/Factsheet-MANUELA\\_INGLES.pdf](https://reproductiverights.org/wp-content/uploads/2021/03/Factsheet-MANUELA_INGLES.pdf).

<sup>155</sup> Brief of Amici International and Comparative Law Scholars, *supra* note 153 at 20-21.

<sup>156</sup> See Brief of Amici International and Comparative Law Scholars, *Whole Woman's Health v. Paxton*, No. 17-51060 (5th Cir. Jan. 11, 2021)

including the human rights obligation of non-retrogression, and the global trend of increasing liberalization of abortion law.<sup>157</sup>

## **VI. Congress Can Secure the Right to Abortion Free from Medically Unnecessary Restrictions and Unconstitutional Bans and Ensure Equal Access Across the Nation by Passing the Women’s Health Protection Act (S.1975).**

The Women’s Health Protection Act is a legislative solution necessary to address the growing disparity in access to abortion care, which is essential for racial, reproductive, and economic justice. By passing the Women’s Health Protection Act, Congress can affirm the rights of every person—regardless of who they are or where they’re from—to make the best health care decisions for themselves, their families, and their lives.

The Act takes crucial steps toward protecting essential reproductive health care and the constitutional and human rights of all people, everywhere, by creating a federal remedy to address the countless individual pieces of legislation imposing bans and targeted, medically unnecessary regulations on abortion. The Act would create explicit federal protections to address the growing disparities in access to abortion, as abortion increasingly becomes more and more difficult to access in large parts of the South and Midwest.

The Women’s Health Protection Act establishes a federal statutory right for health care providers to provide, and their patients to receive, abortion care without arbitrary and frequently-changing barriers to abortion access. The Act identifies a specific set of restrictions that violate that statutory right, including pre-viability abortion bans, requirements that providers give their patients medically inaccurate information, and medically unnecessary tests or procedures, hospitalist admitting privileges requirements, and targeted physical plant requirements. With respect to yet-unseen restrictions that states might invent, the Act lays out a set of criteria that courts may consider in determining whether a restriction violates the statute by singling out and impeding access to abortion. Finally, the bill creates enforcement mechanisms similar to many civil rights and anti-discrimination laws.

The Women’s Health Protection Act will help to ensure that abortion remains accessible across the country.

## **VII. Congress Has the Authority to Protect the Right to Access Abortion Care Across the Nation.**

United States Courts of Appeal have uniformly held that Congress has authority under the Commerce Clause to protect access to abortion.<sup>158</sup> Providing and obtaining abortion services, like other health care is, a form of commercial and economic activity and there is an interstate market for these services. Abortion restrictions substantially affect interstate commerce in numerous ways described in the bill’s findings. Congress has explicitly used its Commerce Clause authority before

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<sup>157</sup> *Id.*

<sup>158</sup> All nine Circuit Courts to address the constitutionality of the Freedom of Access to Clinic Entrances Act held that the Act validly regulated abortion access pursuant to Congress’s Commerce Clause authority. *See Norton v. Ashcroft*, 298 F.3d 547, 556 (6th Cir. 2002) (citing cases); *see also U.S. v. Bird*, 401 F.3d 633, 634 (5th Cir. 2004) (reaffirming prior holding).



to protect access to abortion services and health care providers' ability to provide abortion services.<sup>159</sup> For example, in 1994, Congress invoked this authority when it passed the Freedom of Access to Clinic Entrances Act (FACE Act) to protect access to abortion services and to address protests and blockades at health care facilities where abortion services were provided, as well as associated violence.<sup>160</sup> The Commerce Clause is an independent and sufficient basis for Congress to enact WHPA regardless of Supreme Court law on the constitutional right to abortion.<sup>161</sup>

Further, Congress has the authority under Section 5 of the Fourteenth Amendment to pass legislation like the Women's Health Protection Act when states violate constitutionally protected rights and rely on and reinforce unconstitutional harmful gender stereotypes.<sup>162</sup> For example, Congress used its power to enact the Voting Rights Act of 1965 to safeguard the right to vote under the Fourteenth and Fifteenth Amendments of the Constitution in response to state attempts to prevent people from exercising this right. Repetitive litigation over whether each state's poll tax law was unconstitutional, or whether each new variation of a literacy test or "grandfather" provision was discriminatory or unduly burdensome, would not have sufficed and a federal legislative remedy was warranted. So too, here. The breadth, severity, persistence, increase, and variety in state constitutional violations warrant federal legislation to prevent and remedy these breaches.

Finally, the Necessary and Proper Clause in section 8 of article I of the Constitution, gives Congress the authority to "make all laws which shall be necessary and proper for carrying into Execution" the powers that are vested in it.<sup>163</sup>

The unprecedented volume of attacks on abortion, and the speed at which these attacks have progressed through the legislative process, requires congressional action. Congress can and must protect the constitutional right to abortion, stop the hindrance of this essential health care

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<sup>159</sup> See Freedom of Access to Clinic Entrances Act of 1994, Pub. L. No. 103-259, § 2, 108 Stat. 694 (1994) ("Pursuant to the affirmative power of Congress to enact this legislation under section 8 of article I of the Constitution, as well as under section 5 of the fourteenth amendment to the Constitution, it is the purpose of this Act to protect and promote the public safety and health and activities affecting interstate commerce by establishing Federal criminal penalties and civil remedies for certain violent, threatening, obstructive and destructive conduct that is intended to injure, intimidate or interfere with persons seeking to obtain or provide reproductive health services.").

<sup>160</sup> Freedom of Access to Clinic Entrances Act (FACE Act), 18 U.S.C. § 248.

<sup>161</sup> *U.S. v. Wilson*, 73 F.3d 765, 769 n.4 (1995).

<sup>162</sup> U.S. CONST. amend. XIV, § 5; see *City of Boerne v. Flores*, 521 U.S. 507, 518 (1997) ("[a]ll must acknowledge that § 5 [of the Fourteenth Amendment] is 'a positive grant of legislative power' to Congress" (quoting *Katzenbach v. Morgan*, 384 U.S. 641, 651 (1966))). Section 5 grants Congress power to protect both the Fourteenth Amendment's guarantee of liberty and its guarantee of equality. For example, critical protections in the Family and Medical Leave Act rest on Congress's power to enact legislation that remedies states' reliance on and reinforcement of gender role stereotypes. *Nev. Dep't of Hum. Res. v. Hibbs*, 538 U.S. 721 (2003). Section 5 allows Congress to "enforce[e] guarantees of equal citizenship for women and secur[e] their right to participate in public life on equal terms." Reva Siegel, *The Pregnant Citizen, from Suffrage to the Present*, 19th Amend. Ed. Geo. L.J. 167, 219 (2020).

<sup>163</sup> U.S. CONST. art. I, § 8.

embedded in interstate commerce, and stop the further degradation of reproductive health care by passing the Women’s Health Protection Act.<sup>164</sup>

### **VIII. Conclusion.**

When our constitutionally protected liberties are under sustained attack, Congress has a responsibility to enact legislation protecting them. With the Supreme Court on the cusp of reviewing a direct challenge to *Roe v. Wade*, their first review of an abortion ban since that landmark decision, the time for Congress to act is now. The Women’s Health Protection Act protects the provision of and access to essential reproductive health care and the constitutional rights of all people, no matter where they happen to live. We urge this subcommittee to send the Act to the floor.

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<sup>164</sup> Women’s Health Protection Act of 2021, S. 1975, 117th Cong. (2021) <https://www.congress.gov/bill/117th-congress/senate-bill/1975?r=1&s=1>.