Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR RICHARD BLUMENTHAL

QUESTIONS FOR NANCY NORTHUP:

1. *Ms. Northup, you are the President and CEO of the Center for Reproductive Rights, an organization that frequently works in countries where abortion is illegal or heavily restricted. A 1990 study found that in the United States 62 percent of deaths from illegal abortion and 51 percent of deaths from spontaneous abortion were due to infection. In contrast, only 21 percent of deaths from legal abortions in the United States were caused by infection. Can you comment on the patient safety risks that result from making abortion illegal or from unduly limiting access? Specifically, can you provide a general comparison of the reproductive health outcomes in countries with restrictive abortion laws with the outcomes in countries where abortion is legal, accessible, and safe?*

Response:

The World Health Organization ("WHO") has recognized that "women all over the world are highly likely to have an induced abortion when faced with an unplanned pregnancy – irrespective of legal conditions."[1] Women who live in countries that permit abortion under broad indications are more likely to have access to safe abortion services, whereas in countries with restrictive abortion laws that make abortion illegal in most circumstances, women will often be forced to resort to self-induced abortions or to untrained providers in hazardous environments. The WHO recognizes that in countries with restrictive abortion laws, induced abortion rates are high, most abortions are unsafe, and women's health and lives are frequently jeopardized.[2] For example, according to a study by the WHO and the

[1] WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2008 6 (6th ed., 2011).
[2] WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 23 (2012).

Guttmacher Institute, the Latin American and African regions had the highest rates of unsafe abortion in 2008.[3] The vast majority of countries in these regions have restrictive abortion laws.[4]

Conversely, in Western Europe, where abortion is generally treated as a covered medical service under nationalized health care systems and compulsory health insurance schemes and is available without restriction as to reason in the early months, abortion rates and maternal mortality due to unsafe abortion are the lowest. For example, according to the same study, the rate of unsafe abortion was less than 0.5% in this region.[5] In countries where abortion is legal, maternal mortality and morbidity are generally lower because abortions are performed by trained professionals in hygienic conditions and are safer, more available, and more affordable.

Evidence from around the world clearly demonstrates the negative reproductive health outcomes that result from restrictive abortion laws. For example, in 1996, South Africa changed its law to permit abortion services without restriction as to reason during the first 12 weeks of pregnancy and thereafter on specific grounds.[6] The former law only permitted abortion to save a woman's life, preserve her physical or mental health, or in cases of rape, incest, or fetal impairment.[7] According to South Africa's National Committee of Confidential Inquiries into Maternal Deaths, the liberalization of the abortion law led to a 91% decline in abortion-related maternal mortality between 1994 and 1998-2001.[8]

---

[3] *See* Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008,* 379 THE LANCET 625, Table 1 (2012).
[4] *See* WHO, *supra* note 2 at 25.
[5] Sedgh et al., *supra* note 3, at Table 1.
[6] Choice on Termination of Pregnancy Act 92 of 1996, § 2 (S. Afr.).
[7] Abortion and Sterilization Act 2 of 1975 (S. Afr.), *reprinted in* INT'L ADVISORY COMMITTEE ON POPULATION AND L., ANNUAL REVIEW OF POPULATION LAW 48 (1975).
[8] Before 1996, abortion was legal only to protect life and health or in the cases of rape, incest, other unlawful intercourse, and some fetal impairments. In 1996, the law was liberalized to permit the service without restrictions pertaining to the woman's reason during the first trimester and thereafter on numerous grounds. Choice on Termination of Pregnancy Act 92 of 1996 (S. Afr.); Rachel Jewkes et al., *The Impact of Age on the Epidemiology of Incomplete Abortions in South Africa After the Legislative Change*, 112 BRIT. J. OBSTETRICS AND GYNAECOLOGY 355 (2005).

In Romania, in 1966, the government restricted the availability of abortion to limited circumstances.[9] During the time these restrictions were in effect, maternal mortality rates skyrocketed.[10] Between 1980 and 1989, 80% of maternal deaths were due to unsafe abortions.[11] After the repeal of the restrictive abortion legislation in 1989, maternal mortality rates dramatically decreased, falling 50% in the first year after the law was repealed.[12] This decline continued and by 1996, the registered number of maternal deaths caused by abortion dropped 76%.[13]

Similarly, in Nepal, where revisions to the country's legal code in 2002 granted women the right to terminate a pregnancy up to 12 weeks without restriction as to reason and later on specific grounds, the removal of restrictions contributed to a decline in complications from unsafe abortion.[14] Specifically, "abortion–related complications fell from 54% to 28% of all maternal morbidities treated at relevant facilities between 1998 and 2009."[15]

2. *During the hearing, some Senate Judiciary Committee Members expressed doubt regarding Congress' authority to enact laws that prevent states from legislating in certain areas or in certain ways. Based on your extensive experience as a litigator and state policy advocate, please provide some examples of federal statutes that limit states' ability to legislate.*

---

[9] *See* DEP'T OF ECON. AND SOC. AFFAIRS, UNITED NATIONS POPULATION DIV., ROMANIA, ABORTION POLICIES: A GLOBAL REVIEW 53-54 (2002) ("Council of State Decree No. 770 of 29 September 1966 restricted abortion to the following situations: the continuance of the pregnancy posed a serious danger to the life of the pregnant woman …; one parent suffered from a serious hereditary disease or a disease likely to cause serious congenital malformations; the pregnant woman suffered from a serious physical, mental, or sensory disorder; the pregnancy resulted from rape or incest; the pregnant woman was over age 45 …; or the pregnant woman had given birth to at least four children that were under her care.").

[10] ROMANIA: A COUNTRY STUDY, GPO FOR THE LIBRARY OF CONGRESS (Ronald D. Bachman, ed., 1989), *available at* http://countrystudies.us/romania/.

[11] *See id.*

[12] *See id.*; WHO, Unsafe Abortion: Global and Regional Estimates of Incidence of a Mortality Due to Unsafe Abortion with a Listing of Available Country Data, Introduction (3rd ed. 1997).

[13] *See* UNICEF, INTERNATIONAL CHILD DEVELOPMENT CENTRE, WOMEN IN TRANSITION: A SUMMARY 117, Table 2.8 (1999); ASTRA NETWORK, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN EUROPE: REPORT TO THE EUROPEAN Union 20 (Jan. 2006).

[14] GUTTMACHER INSTITUTE, MAKING ABORTION SERVICES ACCESSIBLE IN THE WAKE OF LEGAL REFORMS: A FRAMEWORK AND SIX CASE STUDIES 27-28 (Apr. 2012), *available at* http://www.guttmacher.org/pubs/abortion-services-laws.pdf.

[15] Sedgh et al., *supra* note 3, at 631.

Response:

The Supreme Court has consistently held that Congress has the power to ensure equal access to health services in interstate commerce and to ensure equal protection of constitutional rights. The Women's Health Protection Act thus correctly cites two bases of constitutional authority: Article I, Section 8 ("Commerce Clause"), and the Fourteenth Amendment, Section 5. While Congress will sometimes use both powers, particularly when effectuating important rights, e.g., the Freedom of Access to Clinic Entrances Act of 1994 ("FACE") (18 U.S.C.A. § 248), the Civil Rights Act of 1964 (42 U.S.C.A. §§ 2000a-2000h-6), the Age Discrimination in Employment Act of 1976 ("ADEA") (29 U.S.C.A. §§ 621-634), and the Americans with Disabilities Act of 1990 ("ADA") (42 U.S.C. § 12101 *et. seq.*), either power would provide sufficient authority for this legislation.

Commerce Clause

Both health care services generally, and abortion services specifically, have been found to fall within interstate commerce. Two major federal laws addressing access to abortion services are grounded in Commerce Clause authority: FACE and the Partial Birth Abortion Ban Act of 2003 ("PBABA") (18 U.S.C.A. § 1531). In every case in which the constitutionality of FACE has been challenged, it has been upheld as a valid exercise of Congress's commerce powers. *See*, *e.g.*, *Norton v. Ashcroft*, 298 F.3d 547, 559 (6th Cir. 2002); *Hoffman v. Hunt*, 126 F.3d 575, 588 (4th Cir. 1997); *U.S. v. Dinwiddie*, 76 F.3d 913, 919 (8th Cir. 1996); *U.S. v. Soderna*, 82 F.3d 1370, 1373-74 (7th Cir. 1996). In *Gonzales v. Carhart*, the Supreme Court did not rule on Congress' authority to enact the PBABA, but did reference Congress's authority under the Commerce Clause "to regulate the medical profession." 550 U.S. 124, 166 (2007).

The power of Congress to regulate interstate commerce also includes the converse power to restrict states in their regulation of interstate commerce. *See Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001) (Federal Cigarette Labeling and Advertising Act precludes states from enacting more restrictive regulations regarding the location of cigarette advertising when

Congress has already addressed the content of such advertising); *Cipollone v. Liggett Grp.*, 505 U.S. 504 (1992) (Public Health Cigarette Smoking Act of 1969 preempted state requirements regarding labeling of cigarettes that were specifically addressed in the Act's language); *Ray v. Atl. Richfield Co.*, 435 U.S. 151 (1978) (federal Ports and Waterways Safety Act of 1972 foreclosed the imposition of certain more stringent requirements by the state regarding tanker construction and operation). Thus Congress has the power under the Commerce Clause to prohibit the type of burdensome and medically unjustifiable state regulations addressed in the Women's Health Protection Act that are preventing women from getting access in their communities to essential reproductive health services.

A prominent example of Congress restricting the ability of states to legislate is the Employee Retirement Income Security Act of 1974 ("ERISA") (29 U.S.C. § 1144), a federal law (based on Commerce Clause authority) that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. Section 514(a) of ERISA provides that it supersedes any and all state laws insofar as they relate to any employee benefit plan. The breadth of this provision is clear – the definition of "state laws" includes "all laws, decisions, rules, regulations, or other state actions having the effect of law, of any state." 29 U.S.C. § 1144(c)(1). The only exception to this broad preemption is a "savings clause" which provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A).

Another example of Congress abrogating state lawmaking authority is the Federal Aviation Administration Authorization Act ("FAAAA"), which blocks state regulations relating to specific motor transportation questions. Congress enacted the law to *de*regulate this area, and wanted to ensure that states would not pick up where Congress had left off and regulate what had just been deregulated. 49 USCS § 1450(a)(1). A third example is the Airline Deregulation Act of 1978. Like the FAAAA, it blocks any state regulation in an area of transportation that Congress was intentionally deregulating; the whole purpose of the law was to prohibit state laws in an area Congress was choosing *not* to regulate. That federal law provides that "a State, political subdivision of a State, or political authority of at least 2 States

may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart." 49 U.S.C.A. § 41713.

Congress used its Commerce Power to enact The Civil Rights Act of 1964, which bans state and local governments, as well as private actors, from discriminating in a number of areas on the basis of "race, color, religion, sex, or national origin." For example, private actors may not discriminate in any "public accommodations engaged in interstate commerce," and state and local governments cannot deny access to public facilities. The Supreme Court has found that Congress had the authority to regulate a business with discriminatory practices that served mostly interstate travelers in *Heart of Atlanta Motel v. United States*. 379 U.S. 241 (1964). It also ruled that federal civil rights legislation could be used to regulate a restaurant because, although most of its customers were local, the restaurant served food that had previously crossed state lines. *Katzenbach v. McClung*, 379 U.S. 274 (1964); *Willis v. Pickrick*, 231 F. Supp. 396 (N.D.Ga.1964). Additionally, the Fourth Circuit has ruled that if an establishment "serves, or offers to serve" interstate travelers, it must comply with the Act pursuant to Congress' commerce powers. *Wooten v. Moore*, 400 F.2d 239 (4th Cir.), *cert. denied*, 393 U.S. 1083, 21 L. Ed. 2d. 776, 89 S. Ct. 866 (1968).

Other civil rights laws also have been grounded in Congress' power to regulate interstate commerce. Congress enacted the ADEA to prohibit age discrimination in employment, based on both the Fourteenth Amendment and the Commerce Clause. In *EEOC v. Wyoming* the Supreme Court affirmed Congress' use of its Commerce Power to extend the ADEA to cover state and local governments. 460 U.S. 226, 243 (1983). Congress again used its Commerce Power in enacting the ADA, which prohibits certain discrimination by state and local governments, as well as private actors, based on disability. While the Supreme Court has not decided the issue, the Fifth Circuit has held that Congress has the power to apply the ADA to the states.[16]

[16] *See United States v. Mississippi Dep't of Public Safety*, 321 F.3d 495 (5th Cir. 2003) (Congress rationally concluded, in light of Congressional findings, that regulation of employment discrimination was necessary to regulate national market of employment.).

Fourteenth Amendment

Congress has the affirmative power under Section 5 of the Fourteenth Amendment to enforce the provisions of the Fourteenth Amendment, including by enacting legislation to prevent states from "depriv[ing] any person of … liberty … without due process of law," as forbidden by Section 1 of that Amendment. In *Roe v. Wade*, 410 U.S. 113 (1973), the Court ruled that the right to privacy protected by the U.S. Constitution includes the right to terminate a pregnancy, and that the right is "founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action." 410 U.S. 113 at 153. Almost twenty years later, in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State" was reaffirmed and grounded in the Due Process Clause of the Fourteenth Amendment. *Id*. at 846 (plurality opinion). Congress therefore may use its enforcement powers under Section 5 of the Fourteenth Amendment to effectuate the right to abortion.

In enacting FACE, Congress used not only its power to regulate commerce, but also its power under Section 5 of the Fourteenth Amendment. Two federal district courts have upheld Congress' authority under Section 5.[17]

Courts have also upheld Congress' authority under Section 5 to apply the ADEA to state governments. Constitutionality was presumed in *Hodgson v. University of Texas Medical Branch at Galveston*, in which the ADEA was held to abrogate states' Eleventh Amendment sovereign immunity. 953 F. Supp. 168, 169 (S.D. Tex. 1997). Additionally, the U.S. Court of Appeals for the First Circuit held that Congress, under the Fourteenth Amendment, may provide for private suits against states or state officials. *Ramirez v. Puerto Rico Fire Service*, 715 F.2d 694, 700 (1st Cir. 1983).

[17] *United States v. McMillan*, 946 F. Supp. 1254, 1262 (S.D. Miss. 1995); *Riely v. Reno*, 860 F. Supp. 693, 708-09 (D. Ariz. 1994).

Congress also relied on the Fourteenth Amendment, along with the Commerce Clause, to enact the ADA. The U.S. Court of Appeals for the Ninth Circuit has held that in enacting Title II of the ADA, Congress validly abrogated state sovereign immunity pursuant to its Fourteenth Amendment powers. *Dare v. California*, 191 F.3d 1167, 1174 (9th Cir. 1999).

The Voting Rights Act of 1965 (42 U.S.C.A. § 1973) provides a particularly apt parallel to the Women's Health Protection Act, as Congress was responding to state efforts to curtail constitutionally protected rights by limiting states' ability to regulate their voting and election rules, an area of traditional state authority. While the right to vote is guaranteed without regard to race pursuant to the Fourteenth and Fifteenth Amendments, in the years following the Amendment's ratification many states enacted laws and voting rules designed to disenfranchise minority voters by creating an array of structural barriers, including poll taxes and literacy tests. As noted by the 1982 Senate Judiciary Committee Report, "…case-by-case litigation proved wholly inadequate. Justice Department attorneys were spread thinly among numerous lawsuits in many different jurisdictions. … Finally, after long frustration and in the fact [sic] of tenacious resistance, Congress affirmed our fundamental principles by passing the Voting Rights Act in 1965."[18] Section 2 of the Voting Rights Act prohibits any state or local government from imposing any voting law that results in discrimination against racial or language minorities. Additionally, the Act specifically outlaws literacy tests and similar devices, even though literacy tests had been upheld by the Supreme Court in *Lassiter v. Northampton Cnty. Board of Elections*, 360 U.S. 45, 53-54 (1959), based on a legislative record that such devices were used to disfranchise racial minorities[19]

3. *If the Women's Health Protection Act had been federal law at the time that Pennsylvania authorities tried and convicted Kermit Gosnell of multiple crimes, would Gosnell still have been convicted and imprisoned? Would the Women's Health Protection Act have affected the outcome of Gosnell's case in any manner whatsoever?*

[18] S. REP. NO. 97-417, at 5 (1982), *reprinted in* 1982 U.S.C.C.A.N. 177, 182.
[19] *Id*. at 285.

Response:

Kermit Gosnell was an unscrupulous practitioner operating outside the bounds of law and morality. The Women's Health Protection Act would not have affected Pennsylvania's ability to prosecute Gosnell for his horrific crimes: first- and third-degree murder, involuntary manslaughter, conspiracy, criminal solicitation, and running a corrupt organization. The Act would affect none of those laws. Nor would it have affected his prosecution for abortion-specific crimes. He was convicted of blatantly violating Pennsylvania's ban on abortion past the state's legal limit of 24 weeks. The Women's Health Protection Act tracks what the U.S. Supreme Court has consistently said about bans on later abortion: a state may restrict abortion after viability if the law contains exceptions for pregnancies that endanger the woman's life or health. *Compare* Section 4(c)(2) of the Women's Health Protection Act (prohibiting ban on abortion "after fetal viability when, in the good-faith medical judgment of the treating physician, continuation of the pregnancy would pose a risk to the pregnant woman's life or health") *with, e.g.*, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (reaffirming "the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health"). Thus the Act does not alter the existing constitutional standard under which states can, and the vast majority do, ban abortion post-viability. Nor would Pennsylvania's mandatory waiting period and mandatory counseling requirements be affected. Those provisions would not violate Sections 4(a) or 4(c) of the Act, as they do not require in-person provision of the mandated information and thus do not require a woman to make a medically unnecessary visit to a provider of abortion services, nor do they require a visit to an individual or entity that does not provide abortion services. Given the dissimilarities between those provisions of Pennsylvania's law and the measures detailed in Section 4(a) of the bill, it is questionable whether they could be established as violating the "similar measures" provision of Section 4(b). In sum, if Women's Health Protection Act had been law at the time, Kermit Gosnell would still have been convicted for his heinous criminal acts and sentenced to life in prison without the possibility of parole.

The unrelenting efforts by many politicians to reduce access to safe abortion services by interfering with health care professionals' ability to provide such services, making it more difficult and in some cases impossible for them to continue to provide those services, only create more opportunities for unethical and unscrupulous predators like Gosnell to thrive. That is another reason why the Women's Health Protection Act is critically needed, as it would ensure that only laws and regulations that truly advance and protect women's health will stand, and pretextual measures designed to block access to safe, high-quality, legal abortion care will fall.

4. *Would the Women's Health Protection Act force clinicians to provide abortion care if they do not wish to for personal or religious reasons?*

Response:

No. The Women's Health Protection Act addresses the onslaught of underhanded laws and regulations that purport to be about health and safety but in reality are designed to block providers who want to deliver care to women from being able to do so. The Act's stated purpose is "to protect women's health by ensuring that abortion services will continue to be available and that abortion providers are not singled out for medically unwarranted restrictions that harm women by preventing them from accessing safe abortion services." The Act does not compel any person to provide abortion care. Moreover, there are federal statutes that allow healthcare providers to decline to provide abortion services based on their personal religious beliefs. See "Church Amendments," 42 U.S.C.A. §300a-7 *et seq.*; Public Health Service Act, 42 U.S.C.A. § 238n; Affordable Care Act, 42 U.S.C.A. § 18023(b)(4); Weldon Amendment, Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, § 507(d), 128 Stat. 5, 409.[20] The Women's Health Protection Act ensures that those health care providers who

[20] For an overview, *see Overview of Federal Statutory Health Care Provider Conscience Protections*, U.S. Dep't of Health & Human Servs., http://www.hhs.gov/ocr/civilrights/faq/providerconsciencefaq.html (last visited Aug. 6, 2014).

have chosen to provide abortion services are subject to the same health and safety rules as other providers performing medical procedures with comparable risk.

5. *Some Members of the Senate Judiciary Committee as well as some of the witnesses who testified stated that the Women's Health Protection Act would invalidate laws requiring parental involvement in the abortion decision of a minor, laws restricting public insurance coverage of abortion, and all limitations on abortion later in pregnancy. Do you agree that such laws would run afoul of the Women's Health Protection Act?*

Response:

Section 4(d) of the Women's Health Protection Act clearly and unambiguously exempts parental involvement laws, restrictions on insurance programs, and the Partial Birth Abortion Ban Act from its scope of effect. Section 4(d) entitled "Limitation," flatly states that:

> The provisions of this Act shall not apply to laws regulating . . . requirements for parental consent or notification before a minor may obtain an abortion, insurance coverage of abortion, or the procedure described in section 1531(b)(1) of title 18, United States Code.

The Purpose section, Section 2(b), further underscores the limited scope of the law. It explains:

> It is not the purpose of this Act to address all threats to access to abortion (for example, this Act does not apply to . . . restrictions on insurance coverage of abortion, or requirements for parental consent or notification before a minor may obtain an abortion) which Congress should address through separate legislation as appropriate.

Finally, as discussed above, a state prohibition on abortion later in pregnancy after fetal viability would not run afoul of the bill, provided it included the constitutionally required

exception for situations in which continuing the pregnancy would pose a risk to the pregnant woman's life or health.[21]

[21] *See Casey*, 505 U.S. at 846; *Roe*, 410 U.S. at 163-64.

Senate Judiciary Committee Hearing on the Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

QUESTIONS FOR THE RECORD FROM SENATOR CHRIS COONS

QUESTIONS FOR MS. NORTHUP:

1. *Large areas of the country, such as Texas's Rio Grande Valley region have no abortion providers. In states where women have limited access to safe and legal abortions they resort to traveling to other countries like Mexico to get services or turn to unregulated providers. What do we know about the safety of these providers and the impact on women's health?*

Response:

In 2013, the Texas legislature passed House Bill 2 (HB2), a sweeping piece of anti-choice legislation which included several extreme and unnecessary new restrictions on abortion access that have already shuttered clinics across the state. If the final requirement of HB2 is allowed to go into effect, fewer than 10 clinics will remain open to serve the second largest state in the nation, with over 13 million female residents. As you note, there is currently no clinic providing abortion services remaining open in the Rio Grande Valley, which is an extremely poor region of our country with over 1.3 million residents.

Some women will not be able to travel the long distances to find care or overcome the many hurdles that have been enshrined into law in Texas and in other states around the country. Some of these women will take desperate measures to end their pregnancies, including crossing the border into Mexico or finding other ways to purchase miscarriage-inducing drugs on the black market. A 2012 study in Texas found that 7% of women reported attempts to self-abort before seeking medical care, which was **before** the recent closure of approximately one-third of Texas abortion clinics.[22] Since the clinic closures,

[22] Daniel Grossman et al., *The Public Health Threat of Anti-abortion Legislation*, 89 CONTRACEPTION, 73 (2014).

providers have noted the growth in black-market purchases of miscarriage-inducing drugs,[23] and a new report from the Texas Policy Evaluation Project shows a 13% decline in the abortion rate in Texas since the law took effect last November.[24] Although the full impact on women's health from the increase in self-induction and/or utilization of unregulated providers remains unclear, we have no doubt that restrictions that force abortion clinics to close their doors are direct threats to women's health and safety. Ensuring that safe and legal abortion services are available is the best way to prevent women from resorting to desperate measures that could threaten their health and lives.

2. *Do state laws restricting access to abortion disproportionately affect low income and minority women?*

Yes. State laws that restrict access to abortion exacerbate pre-existing health disparities caused by poverty and racial inequality. Restrictions that increase the cost of abortion disproportionately harm lower income women and women of color, who are more likely to experience unintended pregnancy and to seek abortion services.[25] Women of color are significantly overrepresented among women seeking abortion: while 31 percent of all women in the U.S. are Black and Hispanic, they comprise 55 percent of abortion patients.[26] In 2008, almost 16 percent of all women of reproductive age lived below the federal poverty level, and 42 percent of women who obtained abortions had incomes that fell below that line. .[27] Low- and lower-income women who decide to have an abortion must often delay the

[23] *See, e.g.,* Erica Hellerstein*, The Rise of the DIY Abortion in Texas,* ATLANTIC (June 27, 2014, 9:00 AM) http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/; Lindsey Beyerstein, "*Miscarriage Management": The Next Front in the Abortion Wars*, NEW REPUBLIC (Jan. 29, 2014), http://www.newrepublic.com/article/116399/abortion-texas-survives-miscarriage-management; Mary Tuma, *All but Illegal*, THE AUSTIN CHRONICLE (July 25, 2014) http://www.austinchronicle.com/news/2014-07-25/all-but-illegal/.
[24] THE TEXAS POLICY EVALUATION PROJECT, UNIV. OF TEXAS AT AUSTIN, TEXAS STATE ABORTION RATE DECREASES 13 PERCENT SINCE IMPLEMENTATION OF RESTRICTIVE LAW (July 23, 2014), *available at* http://www.utexas.edu/cola/orgs/txpep/releases/hb2-release.php#HB2.
[25] Rachel K. Jones, et al., GUTTMACHER INSTITUTE, CHARACTERISTICS OF U.S. ABORTION PATIENTS, 2008 (2010); Christine Dehlendorf, et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1172 (2013); Mia Zolna & Laura Lindberg, GUTTMACHER INSTITUTE, UNINTENDED PREGNANCY: INCIDENCE AND OUTCOMES AMONG YOUNG ADULT UNMARRIED WOMEN IN THE UNITED STATES, 2001 AND 2008 (2012); Katherine Gallagher Robbins & Lauren Frohlich, NATIONAL WOMEN'S LAW CENTER, NATIONAL SNAPSHOT: POVERTY AMONG WOMEN & FAMILIES, 2012 (2013).
[26] Black and Hispanic women comprise 26.5% of U.S. women. Jones et al., *supra* note 27 at 8.
[27] Jones, et al., *supra* note 27 at 8.

procedure in order to raise the necessary funds, which drives up the cost and increases the risk of the procedure.[28] When unnecessary state restrictions force women to make multiple trips to the clinic and/or travel long distances, the cost of the procedure is compounded through lost wages and additional transportation and child care costs.[29] Furthermore, state restrictions that increase cost magnify the effects of racial disparities in access to care: women of color are at a higher risk than white women of living in poverty and have consistently poorer access to regular, high-quality health care services and family planning.[30]

The health and human rights of low-income women and women of color are significantly undermined by state laws that impose medically unnecessary barriers to abortion access. The Women's Health Protection Act would begin to address some of these barriers by dismantling restrictions that target abortion providers, do not promote women's health, and ultimately threaten the well-being of many women, especially those who the most underserved and marginalized.

[28] Heather D. Boonstra, GUTTMACHER INSTITUTE, THE HEART OF THE MATTER: PUBLIC FUNDING OF ABORTION FOR POOR WOMEN IN THE UNITED STATES (2007); Theodore J. Joyce et al., GUTTMACHER INSTITUTE. THE IMPACT OF STATE MANDATORY COUNSELING AND WAITING PERIOD LAWS ON ABORTION: A LITERATURE REVIEW (2009).
[29] Boonstra, *supra* note 30; Sarah Jane Glynn & Jane Farrell, CENTER FOR AMERICAN PROGRESS, LATINOS LEAST LIKELY TO HAVE PAID LEAVE OR WORKPLACE FLEXIBILITY (2012); Tara Culp-Ressler, *By the Numbers: Why Most U.S. Women Struggle to Afford Abortion*, THINK PROGRESS (May 8, 2013), http://thinkprogress.org/health/2013/05/08/1979831/women-struggle-afford-abortion.
[30] Alexandra Cawthorne, *The Straight Facts on Women in Poverty*, CENTER FOR AM. PROGRESS (Oct. 8, 2008), http://www.americanprogress.org/issues/women/report/2008/10/08/5103/the-straight-facts-on-women-in-poverty; Robbins & Frohlich, *supra* note 27; GUTTMACHER INSTITUTE, FACT SHEET: INDUCED ABORTION IN THE UNITED STATES (July 14, 2014, 10:57 AM), http://www.guttmacher.org/pubs/fb_induced_abortion.html.