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Hearing of the Senate Judiciary Committee,
Subcommittee on the Constitution
"Protecting *Roe*: Why We Need the Women's Health Protection Act"

June 16, 2021, 2:30 p.m.
Dirksen Senate Office Building, Room 226

Dear Chair Blumenthal, Ranking Member Cruz, and Members of the Committee:

I am deeply privileged to testify before this Committee on the Women's Health Protection Act. I serve as President & CEO of Americans United for Life (AUL), America's original and most active pro-life legal advocacy organization. Founded in 1971, two years before the Supreme Court's decision in *Roe v. Wade*, AUL has dedicated 50 years to advocating for comprehensive legal protections for human life from conception to natural death. AUL attorneys are highly regarded experts on the Constitution and legal issues touching on abortion and are often consulted on various bills, amendments, and ongoing litigation across the country.

The Women's Health Protection Act does everything but protect women's health. It impedes the States' legitimate interest in protecting life, attempts to negate currently existing commonsense protections for women's health, and prohibits any such protections from being enacted in the future.

I. The Act effectively bans all state abortion regulations before viability, including those that have been upheld by the courts.

The Act would significantly limit the States' ability to enact desperately needed public policy that furthers the Supreme Court-sanctioned goals of protecting the health and safety of women and girls and valuing human life. By banning virtually all state laws before viability, the Act would prevent basic regulation and oversight crucial to keeping women safe. Some changes that could result include: removing protections for the health of the mother and child, watering down informed consent so she's unaware of and unable to consider all her options, and removing protections against coerced abortion, sex-selective abortion, and abortion based on genetic anomalies such as Down syndrome. It could prevent sex-trafficking reporting and information preventing coerced abortion. The changes sought by the passage of this Act are unnecessary and harm women.

a. Section 4(a)(8) seeks to invalidate limitations on abortion before viability, which is actually harmful to women's health.

Abortions carry a higher medical risk when done later in pregnancy. Even Planned Parenthood, the largest abortion business in the United States, agrees that abortion becomes riskier later in pregnancy. On its national website, Planned Parenthood states: "The chances of problems gets higher the later you get the abortion, and if you have sedation or general anesthesia . . . ," which would be

necessary for an abortion at or after 20 weeks of gestation.[1] To put this in context, "[i]t is estimated that about 1% of all abortions in the United States are performed after 20 weeks, or approximately 10,000 to 15,000 annually."[2]

Gestational age is the strongest risk factor for abortion-related mortality, and the incidence of major complications is significantly higher after 20 weeks' gestation.[3] For example, compared to an abortion at 8 weeks' gestation, the relative risk of mortality increases exponentially (by 38 percent for each additional week) at higher gestations.[4] Specifically, the risk of death at 8 weeks is reported to be one death per one million abortions; at 16 to 20 weeks, that risk rises to 1 per every 29,000 abortions; and at 21 weeks or more, the risk of death is 1 per every 11,000 abortions.[5] In other words, a woman seeking an abortion at 20 weeks is 35 times more likely to die from abortion than she was in the first trimester. And at 21 weeks or more, she is 91 times more likely to die from abortion than she was in the first trimester.

Further, researchers have concluded that it may not be possible to reduce the risk of death in later-term abortions because of the "inherently greater technical complexity of later abortions."[6] This is because in later-term abortions there is a greater degree of cervical dilation needed, the increased blood flow predisposes to hemorrhage, and the myometrium is relaxed and more subject to perforation.

In addition to the mortality risks, later-term abortions also pose an increased risk for maternal health. Some immediate complications from abortion include blood clots, hemorrhage, incomplete abortions, infection, and injury to the cervix and other

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[1] *See* Planned Parenthood, *How Safe Is An In-Clinic Abortion?*, https://www.plannedparenthood.org/learn/abortion/in-clinic-abortion-procedures/how-safe-is-an-in-clinic-abortion (last visited June 15, 2021).

[2] James Studnicki, *Late-Term Abortion and Medical Necessity: A Failure of Science*, 6 HEALTH SERVS. RESEARCH AND MANAGERIAL EPIDEMIOLOGY, 1 (2019).

[3] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 731 (2004); Janet P. Pregler & Alan H. DeCherney, WOMEN'S HEALTH: PRINCIPLES AND CLINICAL PRACTICE 232 (2002). *See also* Slava V. Gauferg, *Abortion Complications*, https://emedicine.medscape.com/article/795001-overview (updated Jun. 24, 2016) (Several large-scale studies have revealed that abortions after the first trimester pose more serious risks to women's physical health than first trimester abortions).

[4] Barlett, *supra* note 3; Professional Ethics Comm. of Am. Assoc. of Pro-Life Obstetricians & Gynecologists, *Induced Abortion & the Increased Risk of Maternal Mortality*, Comm. Op. 6 (Aug. 13, 2019).

[5] Barlett, *supra* note 3.

[6] *Id.* at 735.

organs.[7] Immediate complications affect approximately 10% of women undergoing abortion, and approximately one-fifth of these complications are life-threatening.[8]

States have a legitimate interest in preventing abortions later in pregnancy which present increased risk to the mother's health, and nearly all states—43 and counting—have acted on this interest by enacting laws that restrict elective abortions at or before "viability".[9]

In addition to protecting mothers, States also have a legitimate interest in preventing fetal pain. Dr. Warren Hern of Boulder, Colorado, one of the only doctors in the United States to perform abortions after 30 weeks, estimates only a third of the late-term abortions he performs are because of a significant fetal health issue.[10] Gestational age limitations are designed to protect the remaining seventy percent of preborn babies from elective abortion.[11] As to why women may seek later-term abortions, a report published in the Alan Guttmacher Institute journal Perspectives on Sexual and Reproductive Health states, "[D]ata suggest that most women seeking later terminations are not doing so for reasons of fetal anomaly or life endangerment."[12] The report provides "five general profiles of women who sought later abortions, describing 80% of the sample:" women who were "raising children alone, were depressed or using illicit substances, were in conflict with a male partner or experiencing domestic violence, had trouble deciding and then had access problems, or were young and nulliparous (had never given birth)."[13]

There is substantial medical evidence that a preborn child is capable of experiencing pain at least by 20 weeks after fertilization, if not earlier.[14] In 2019,

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[7] *See* Planned Parenthood, *supra* note 1.
[8] E. Shadigian, *Reviewing the Medical Evidence: Short and Long-Term Physical Consequences of Induced Abortion,* Testimony before the South Dakota Task Force to Study Abortion, Pierre, South Dakota (Sept. 21, 2005).
[9] Michelle Ye Hee Lee, *Is the United States One of Seven Countries That "Allow Elective Abortions After 20 Weeks of Pregnancy?",* THE WASHINGTON POST (Oct. 9, 2017) https://www.washingtonpost.com/news/fact-checker/wp/2017/10/09/is-the-united-states-one-of-seven-countries-that-allow-elective-abortions-after-20-weeks-of-pregnancy/.
[10] Anna Staver, *Why a NY Woman Came to Colorado for a 32-Week Abortion*, THE DENVER POST (Oct. 13, 2019) https://www.denverpost.com/2019/10/13/late-abortion-women-2020/.
[11] Dr. Hern admits that around one fourth of all late-term abortions he performed were because of a Down syndrome diagnosis, which is an elective abortion; *see* Warren M. Hern, *Fetal Diagnostic Indications for Second and Third Trimester Outpatient Pregnancy Termination*, 34 PRENATAL DIAGNOSIS 438 (2014).
[12] Diana Greene Foster & Katrina Kimport, Who Seeks Abortions At or After 20 weeks? Perspectives on Sexual and Reprod. Health, (2013) https://onlinelibrary.wiley.com/doi/full/10.1363/4521013.
[13] *Id*.
[14] Federal Pain Capable Act S. 160, Sec. 2(1)–(11).

scientists found evidence of fetal pain as early as 12 weeks' gestation.[15] A study from 2010 found that "the earlier infants are delivered, the stronger their response to pain"[16] because the "neural mechanisms that inhibit pain sensations do not begin to develop until 34-36 weeks[] and are not complete until a significant time after birth."[17] As a result, preborn children display a "hyperresponsiveness" to pain.[18] According to one group of fetal surgery experts, "The administration of anesthesia directly to the fetus is critical in open fetal surgery procedures."[19] It is well within the legitimate interests of the State to minimize fetal pain as much as possible[20] and many states have acted on this legitimate interest of protecting both maternal health and the preborn child.

Currently 18 states maintain an enforceable limitation on abortion at or before 20 weeks postfertilization: Alabama, Arkansas, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, West Virginia, and Wisconsin. This Act will erase the States' work at furthering their legitimate interests.

b. Section 4(a)(11) seeks to invalidate antidiscrimination laws designed to protect preborn children from discrimination on the basis of race, sex, or genetic abnormality.

Race-based discrimination is "odious in all aspects."[21] Our nation is currently grappling with its legacy of racial discrimination and the deep wounds it has caused. The color of our skin should never impact how we are treated in any way, including in the womb. A preborn person of color is owed freedom and equality, the birthright of every human being. Too often, our society has looked the other way when abortion is used as a tool of oppression, ending the lives of persons of color before they take their first breath.

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[15] Stuart W.G. Derbyshire & John C. Bockmann, *Reconsidering Fetal Pain*, 46 JOURNAL OF MEDICAL ETHICS 3 (2020).
[16] Lina K. Badr et al., *Determinants of Premature Infant Pain Responses to Heel Sticks*, 36 PEDIATRIC NURSING 129 (2010).
[17] Charlotte Lozier Institute, *Fact Sheet: Science of Fetal Pain*, https://lozierinstitute.org/fact-sheet-science-of-fetal-pain/#_ednref14 (last updated Feb. 19, 2020).
[18] Christine Greco and Soorena Khojasteh, *Pediatric, Infant, and Fetal Pain*, CASE STUDIES IN PAIN MANAGEMENT 379 (2014).
[19] Maria J. Mayorga-Buiza et al., *Management of Fetal Pain During Invasive Fetal Procedures. Lessons Learned from a Sentinel Event*, 31 EUROPEAN JOURNAL OF ANAESTHESIOLOGY 188 (2014).
[20] *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.")
[21] *See Box v. Planned Parenthood of Indiana and Kentucky*, 139 S. Ct. 1780, 1792 (2019) (Thomas J., concurring) (citing *Pena-Rodriguez v. Colorado*, 580 U.S. 855, 867 (2017).

Justice Clarence Thomas worried that "technological advances have only heightened the eugenic potential for abortion, as abortion can now be used to eliminate children with unwanted characteristics."[22] He lays out the history of the American eugenics movement and its link to the precursors of the modern abortion industry, stating that "this law and other laws like it promote a State's compelling interest in preventing abortion from becoming a tool of modern-day eugenics."[23] Denying any child the right to life based on the color of his or her skin is an injustice that States are seeking to prevent.

A sex-selection abortion is an abortion undertaken to eliminate a child of an undesired sex. Importantly, the targeted victims of such abortions are overwhelmingly female. The practice of sex-selection abortion has drawn increasing attention in the U.S. and worldwide. The problem is so severe in some countries that in 2005 the United Nations Population Fund (UNFPA) termed the practice "female infanticide." The UNFPA described this as a "symptom of pervasive social, cultural, political and economic injustices against women, and a manifest violation of women's human rights."[24] According to the UNFPA, recent studies have shown 140 million girls "are considered missing today as a consequence not only of gender-biased sex selection but also of postnatal sex selection."[25] Writer Mara Hvistendahl estimates the number is closer to 163 million worldwide.[26] Even Hillary Clinton identified sex-selection abortions as part of abuse against women. In a 2009 interview, then-Secretary Clinton stated that "unfortunately with technology, parents are able to use sonograms to determine the sex of a baby, and to abort girl children simply because they'd rather have a boy."[27]

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[22] *Id.* at 1784.
[23] *Id.* at 1783.
[24] United Nations Population Fund Asia & Pacific Regional Offices, *Sex Imbalances at Birth: Current Trends, Consequences and Policy Implications* (Aug. 2012), https://www.unfpa.org/sites/default/files/pub-pdf/Sex%20Imbalances%20at%20Birth%20PDF%20UNFPA%20APRO%20publication%202012pdf.
[25] United Nations Population Fund, *Gender-Biased Sex Selection*, https://www.unfpa.org/gender-biased-sex-selection (last visited June 15, 2021).
[26] Mara Hvistendahl, UNNATURAL SELECTION: CHOOSING BOYS OVER GIRLS, AND THE CONSEQUENCES OF A WORLD FULL OF MEN 5–11 (2011). Over the past few decades, approximately 300,000 to 700,000 girls in India were selectively aborted annually. Sital Kalantry, *How to Fix India's Sex-Selection Problem*, NEW YORK TIMES (Jul. 27, 2017) https://www.nytimes.com/2017/07/27/opinion/how-to-fix-indias-sex-selection-problem.html; *see also* Nicholas Eberstadt, *The Global War Against Baby Girls,* THE NEW ATLANTIS (2011), https://www.thenewatlantis.com/docLib/20111214_TNA33Eberstadt.pdf (noting sex-selective infanticide is also occurring in other countries as well, including China and Vietnam).
[27] Mark Landler, *A New Gender Agenda*, THE NEW YORK TIMES MAGAZINE, Aug. 18, 2009 http://www.nytimes.com/2009/08/23/magazine/23clinton-t.html?_r=0.

Some studies have found that sex-selection abortions are being done in the United States.[28] For example, researchers concluded that the most logical explanation for the irregularity in boy-birth percentages in the United States is gender selection. Given the high expense and rarity of advanced reproductive technologies such as *in vitro* fertilization (IVF) or sperm sorting, this gender selection is most likely taking place by abortion.[29] Analysis also revealed a deviation in favor of sons in Western society to be evidence of sex selection, most likely at the prenatal stage.[30] One survey found that there still exists a moderate "tendency for American adults to express overall preferences for a boy over a girl."[31] Even the efforts of pro-abortion advocates to defeat bans on sex-selection abortions by claiming these abortions are rare acknowledge that sex-selection abortions happen.

Sadly, abortions based on a diagnosis of a genetic abnormality are becoming increasingly common as prenatal testing diagnoses intended to provide parents and healthcare providers with information about a preborn baby's health and development, as well as the child's sex, are given earlier in pregnancy. Prenatal testing can be a valuable tool for diagnosing and treating conditions that threaten the health or life of the mother and/or the child. However, in some cases and despite the documented error rates for such testing, it is also being used as a precursor for aborting a child of an undesired sex or with potential genetic abnormalities. For example, some studies have indicated that somewhere between 50 and 90 percent of children diagnosed with Down syndrome are aborted.[32] Clearly, this chilling slide toward eugenics—specifically eliminating persons with certain hereditary characteristics—must be confronted.

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[28] *See* J. Coppage, *Here's the "Missing" Evidence for S.D.'s Sex-Selective Abortion Ban* (Apr. 1, 2014), http://www.theamericanconservative.com/here's-the-missing-evidence-for-sex-selective-abortion-bans-south-dakota/ (citing D. Almond & L. Edlund, *Son-Biased Sex Ratios in the 2000 United States Census*, Proceedings of the Nat'l Acad. of Sci. of the U.S.A. (2008), http://www.pnas.org/content/105/15/5681.full; J. Abrevaya, *Are There Missing Girls in the United States? Evidence from Birth Data*, Amer. Econ. J. Applied Econ. (2009), https://www.aeaweb.org/articles?id=10.1257/app.1.2.1.

[29] *Id.*

[30] *Id.*

[31] Frank Newport, *Slight Preference for Having Boy Children Persists in U.S.*, Gallup https://news.gallup.com/poll/236513/slight-preference-having-boy-children-persists.aspx (July 5, 2018).

[32] Jaime L. Natoli et al., *Prenatal Diagnosis of Down Syndrome: A Systematic Review of Termination Rates (1995-2011)*, 32 PRENATAL DIAGNOSIS 142 (2012); Caroline Mansfield et al., *Termination Rates After Prenatal Diagnosis of Down Syndrome, Spina Bifida, Anencephaly, and Turner and Klinefelter Syndromes: A Systematic Literature Review*, PRENATAL DIAGNOSIS (1999); D.W. Brit et al., *Determinants of Parental Decisions After the Prenatal Diagnosis of Down Syndrome: Bringing in Context*, AM. J. MED. GENETICS (1999).

The U.N. Committee on the Rights of Persons with Disabilities (CRPD), stated "[l]aws which explicitly allow for abortion on grounds of impairment violate the Convention on the Rights of Persons with Disabilities." The CRPD rejected the idea that a prenatal diagnosis of a genetic abnormality is "incompatible with life" and noted that "experience shows that assessments on impairment conditions are often false," but affirmed that even if the diagnosis turns out to be accurate, discriminating on the basis of genetic abnormalities "perpetuates notions of stereotyping disability as incompatible with a good life."[33]The U.S. Congress has additionally found that "physical or mental disabilities in no way diminish a person's right to fully participate in all aspects of society, yet many people with physical or mental disabilities have been precluded from doing so because of discrimination."[34] In fact, polling has shown that 99 percent of people with Down syndrome are happy with their lives, 99 percent of parents of Down syndrome children love their child, and 97 percent of children aged 9 to 11 with a sibling with Down syndrome love them and are proud of them.[35]

As stated in *Gonzales v. Carhart*, the Supreme Court "has confirmed the validity of drawing boundaries to prevent certain practices that extinguish life and are close to actions that are condemned."[36] Discriminating on the basis of race, sex, or genetic disability has been condemned; it is thus natural to extend this protection against discrimination to life in the womb. If the State has an interest in stopping discrimination based on race, sex, or disability, the State should also have an interest in preventing discrimination on these bases by stopping eugenics. This Act would bar the States from acting to prevent documented discrimination against people with developmental disabilities.

II. By leaving certain terms undefined, this Act opens up unrestricted abortion on demand in every state.

a. "Health" is undefined, and under the *Doe* definition, could reasonably include virtually any reason.

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[33] *See, e.g.*, Susan Yoshihara, *Another U.N. Committee Says Abortion May Be a Right, But Not on Basis of Disability*, Center for Family and Human Rights, Oct. 26, 2017, https://c-fam.org/friday_fax/another-un-committee-says-abortion-may-right-not-basis-disability/.
[34] 42 U.S.C. § 12101(a).
[35] Mark Bradford, *Improving Joyful Lives: Society's Response to Difference and Disability*, Charlotte Lozier Institute American Reports Series Issue 8, (June 2014), https://lozierinstitute.org/improving-joyful-lives-societys-response-to-difference-and-disability/.
[36] 550 U.S. at 158.

The Act seeks to invalidate the majority of state laws governing abortion and ensure access to cover the undefined "health" of the woman. The Supreme Court considers "health" to include all factors, including "physical, emotional, psychological, familial, and the woman's age" for the purposes of post-viability abortions.[37] In some states, "health" has been so broadly defined as to include "financial health." By refusing to define or limit "health," the Act allows for abortion up to the moment of delivery of the child which effectively creates abortion on demand at any point in the pregnancy. Furthermore, by stating that any law which imposes on "health" in any way violates the Act, theoretically anything that costs any money or causes any stress (like most doctor's visits) stands in violation of the Act.

b. "Medically inaccurate information" is undefined yet nevertheless prohibited by section 4(a)(3).

The Act prohibits offering "medically inaccurate information" but by failing to define what is considered "inaccurate," the door is open to remove crucial information provided during informed consent only because the abortion industry does not wish to provide it.

In 1992, the U.S. Supreme Court upheld Pennsylvania's 24-hour informed consent law, which required "a woman seeking an abortion give her informed consent prior to the abortion procedure, and specifie[d] that she be provided with certain information at least 24 hours before the abortion is performed."[38] In doing so, the Court recognized that "the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus."[39] It determined that "the giving of truthful, nonmisleading information about the nature of the abortion procedure, the attendant health risks and those of childbirth, and the probable gestational age of the fetus" as well as "requiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to ensure an informed choice," was not a substantial obstacle and did not impose an undue burden on abortion rights, even if it "might cause the woman to choose childbirth over abortion."[40]

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[37] *Doe v. Bolton*, 410 U.S. 179, 192 (1973). This was later circumscribed by legitimate state interests. *See Casey*, 505 U.S. 833 (1992).
[38] *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992).
[39] *Id*. at 846.
[40] *Id*. at 882–83.

Informed consent helps women make informed choices. Informed consent laws "are part of the state's reasonable regulation of medical practice"[41] and reduce "the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."[42] The decision to abort "is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences."[43] It is essential to the psychological and physical well-being of a woman considering an abortion that she receives complete and accurate information on abortion and its alternatives because "[t]he point of informed consent laws is to allow the patient to evaluate her condition and render her best decision under difficult circumstances."[44]

The knowledgeable exercise of a woman's decision to have an abortion depends on the extent to which she receives sufficient information to make an informed choice between two alternatives: giving birth or having an abortion. This Act would deny women the information needed to make a fully informed choice. This vital information includes the medical risks associated with both abortion and carrying the child to term, the probable gestational age of the preborn child, and that medical assistance benefits are available for prenatal care, childbirth, and neonatal care. It would also deny women the opportunity to receive materials detailing agencies available to assist the woman through pregnancy, adoption agencies, and materials detailing the anatomical characteristics of the preborn child. Only by receiving all information can the woman weigh all options and, with all the facts, determine what the next step should be.

The offer to view an ultrasound provides a woman the option to see her preborn child, an effective step the State can take to ensure that the woman's consent for an abortion is as fully informed as possible. Ultrasound provisions promote the woman's physical and psychological health[45] and serve an essential and irreplaceable medical purpose in that they are the only method of diagnosing ectopic pregnancies, which, if left undiagnosed, can result in infertility or even fatal blood loss.[46] Furthermore, an ultrasound enables the healthcare provider to more accurately date the gestational

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[41] *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 576 (5th Cir. 2012).
[42] *Casey*, 505 U.S. at 882.
[43] *Planned Parenthood v. Danforth*, 428 U.S. 52, 67 (1976).
[44] *Lakey*, 667 F.3d at 579.
[45] In both *Carhart* and *Casey*, the Supreme Court affirmed "the principle that the State has legitimate interests from the outset of pregnancy in protecting the health of the woman." *Gonzales*, 550 U.S. at145 (quoting *Casey*, 505 U.S. at 846 (citing *Roe v. Wade*, 410 U.S. 113 (1973))).
[46] *See*, *e.g.*, Mayo Clinic, *Ectopic Pregnancy*, Dec. 18, 2020, http://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/basics/complications/con-20024262.

age of a child. Accurate dating of pregnancy both protects the woman by ensuring that the appropriate abortion procedure is performed and provides relevant information necessary to make an informed decision, since the risks of abortion increase as gestational age increases.

Informed consent for elective procedures—such as abortion—need not be made under pressure since there is time to discuss information the woman would consider relevant, such as the risks, benefits, and nature of the procedure she might undergo.[47] Reflection periods—like the 24 hour period required by many states—help ensure the woman has the time she needs to take all the given information into account without the pressure of making an immediate decision since the "medical, emotional, and psychological consequences of an abortion are serious and can be lasting."[48] In fact, the Supreme Court determined waiting periods were not an "undue burden" and "the idea that important decisions will be more informed and deliberate if they follow some period of reflection" was not "unreasonable."[49]

A majority of states have enforceable informed consent and reflection period laws. Twenty-eight states require written materials be either given or offered.[50] Twenty-five states require specific information be given on the abortion procedure.[51] Thirty-one states require the woman be informed of the probable gestational age of her fetus.[52] Twenty-six states have a reflection period ranging from eighteen to seventy-two hours.[53] None of the informed consent requirements remotely limit a woman's ability to obtain a legal abortion; however, they do ensure that every woman is fully informed about all of her options. The Act would strike down most—if not

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[47] *See*, *e.g.,* Owen A. Anderson & Mike J. Wearne, *Informed Consent for Elective Surgery—What is the Best Practice?*, 100 J. Royal Soc'y of Med. 97 (2007).
[48] *H.L. v. Matheson,* 450 U.S. 398, 411 (1981).
[49] *Casey*, 505 U.S. at 885.
[50] These states are Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wisconsin.
[51] These states are Alabama, Alaska, Arizona, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Utah, and Wisconsin.
[52] These states are Alabama, Alaska, Arizona, Arkansas, Connecticut, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wisconsin.
[53] These states are Alabama, Arizona, Arkansas, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wisconsin.

all—of these laws, even those that have been explicitly upheld by the Supreme Court, leaving a woman with just the information the abortion business decides to provide.

c. Section 4(a)(6) prohibits limitations on the building, equipment, or staff of an abortion clinic unless it is similar to a facility where "medically comparable procedures are performed."

Prohibiting any limitation on abortion clinics and staff unless comparable to limitations on "medical procedures that are similar in terms of health and safety risks to the patient, complexity, or the clinical setting that is indicated" is vague and leaves open the possibility the abortion industry would become completely unregulated. The Supreme Court explained that "a State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life."[54] The Court reiterated in *Whole Woman's Health v. Hellerstedt* that States have "a legitimate interest in seeing to it that abortion, like any medical procedure, is performed under circumstances that insure maximum safety for the patient."[55] As a reflection of its legitimate interest in protecting life, a State may pass common-sense health and safety abortion regulations, including provisions to ensure the informed consent and health of a woman who chooses to have an abortion.[56] Many States regulate freestanding abortion clinics in a specific way to address the uniqueness of that industry, for example, the higher amount of human tissue needing safe and sanitary disposal. Yet the Act would not allow States to account for these differences when creating and enforcing oversight regulations. In blatant disregard of the State's prerogative, the Act circumscribes the States' ability to act upon its legitimate interest in ensuring women's health and safety.

d. Section 4(a)(7) prohibits "medically unnecessary" in-person visits which, in conjunction with Sections 4(a)(4) and (5), will render chemical abortions incredibly dangerous.

In-person requirements as part of the chemical abortion regimen are a necessary medical safeguard that the FDA and nearly half of the States have maintained for two decades. However, the vague restriction against "medically

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[54] *Roe*, 410 U.S. at 154.

[55] 790 F.3d 563, 567 (2016) (quoting *Roe*, 410 U.S. at 150).

[56] *See*, *e.g.*, *Casey*, 505 U.S. at 883 ("[R]equiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to ensure an informed choice, one which might cause the woman to choose childbirth over abortion. This requirement cannot be considered a substantial obstacle to obtaining an abortion, and, it follows, there is no undue burden").

unnecessary" in-person visits suggests this important safeguard will be prohibited by this Act.

Who decides what is "medically unnecessary?" Since Mifeprex was approved by the FDA in 2000, [57] it has been approved only with regulations that include an "in-person dispensing requirement." [58] This means that a physician must meet with her patient in-person to prescribe and administer the abortion-inducing drug regimen, or "chemical abortion pill." Although it has chosen to temporarily not enforce the requirement because of COVID-19, the FDA has deemed at least one in-person appointment to be medically necessary for twenty years.

Medical institutions are in agreement about this; according to the world-renowned University of California-San Francisco Health Center, "a medical abortion involves at least two visits to a doctor's office or clinic."[59] Before the abortion, a healthcare provider must first confirm she is a medically appropriate candidate for chemical abortion.[60] Even the "TelAbortion Study" sponsored by Gynuity Health Projects requires at least two in-person appointments, one before and one after the abortion.[61]

Yet the American College of Obstetricians and Gynecologists (ACOG), a pro-abortion trade group, filed a lawsuit in early 2020 seeking to invalidate the Food and Drug Administration's (FDA) "in-person dispensing requirement"[62] under the guise of COVID-19 prevention. Despite publishing practice manuals as recently as 2019 that advise physicians to evaluate patients in-person prior to prescribing mifepristone, ACOG has done an about face and encourages prescribing chemical abortion pills over video chat and administering them through the mail.[63]

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[57] *Mifeprex (Mifepristone) Information,* U.S. Food and Drug Admin., (Feb. 5, 2018), http://www.fda.gog/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.
[58] *Id.*
[59] *Medical Abortion*, University of California San Francisco, UCSF Health (2020), www.ucsfhealth.org/treatments/medical-abortion.
[60] In most states, this consultation is with a physician. In a few states, like California, it can be done by a midlevel provider, such as a nurse practitioner, certified nurse-midwife, or physician assistant. Steven H. Aden, *Defending Life 2020: Everyone Counts,* Americans United for Life, (2019), at 45.
[61] *FAQs*, The TelAbortion Project, (2020), https://telabortion.org/faqs.
[62] *Id.*
[63] *Am. Coll. of Obstetricians and Gynecologists v. U.S. Food and Drug Admin.*, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017 (D. Md. July 13, 2020).

So who decides what is medically necessary? Is it the FDA, medical institutions, an HHS bureaucrat, the abortion doctor with a financial incentive in speeding up the process? The Act doesn't say.

Many States have enacted laws that codify medical best practices. These include: using ultrasound to evaluate whether someone is an appropriate candidate for the chemical abortion pill based on fetal location[64] and gestational age[65] and Rh-negativity blood testing to treat for Rh-incompatibility which can lead to serious fertility problems.[66] Many States include questions about consent, intimate partner violence, and reproductive control to ensure that the woman is not being coerced into having the abortion.[67] The "no questions asked" approach taken by the Act is a gift to traffickers and abusers that will not help a single woman escape an abusive situation.

It is impossible to reach the medical certainty needed to prescribe abortion pills through a video chat. Telemedicine abortion would increase the likelihood of coerced abortion or that the pills are taken by someone who is not medically eligible for the drug regimen and will suffer complications without a doctor's supervision.

Several States have already explicitly prohibited at-home abortions via telemedicine, recognizing the inherent risks to women.[68] And around twenty states have laws requiring that abortion-inducing drugs be prescribed and supplied directly from the physician in a clinical setting.[69] Yet the Act could prohibit States from enforcing medical best practices and create a regime of tele-abortion across the country. A doctor in California could ship pills to Texas with zero follow up or ability to help if the woman suffers any of the serious complications endemic to chemical abortion. Furthermore, they would be unavailable for a follow up appointment to ensure that she does not have any retained fetal tissue. This is simply not good medicine.

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[64] Mayo Clinic, *Ectopic Pregnancy*, *Diagnosis & Treatment*, (Dec. 18, 2020), www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/diagnosis-treatment/drc-20372093.

[65] Comm. on Obstetric Practice Am. Inst. of Ultrasound in Med. Soc'y for Maternal-Fetal Medicine, *Methods for Estimating the Due Date*, Committee Op. No. 700, (May 2017), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date.

[66] *Frequently Asked Questions*, RhoGAM Ultra-Filtered PLUS, (Apr. 2019), http://www.rhogam.com/faq/.

[67] Comm. on Health Care for Underserved Women, *Reproductive and Sexual Coercion*, Comm. Op. No. 554, at 2 (Feb. 2013) (internal citation omitted).

[68] These are: Arizona, Idaho, Montana, Ohio, Oklahoma, West Virginia, and Wisconsin.

[69] Amanda Stirone, *State Regulation of Telemedicine Abortion and Court Challenges to Those Regulations*, 24 On Point (July 2018), https://s27589.pcdn.co/wp-content/uploads/2018/07/State-Regulation-of-Telemedicine-Abortion-and-Court-Challenges-to-Those-Regulations.pdf.

III. This Act circumvents the will of the American people who have passed laws limiting abortion in various ways.

This Act would invalidate hundreds of state laws, leaving the abortion industry virtually unregulated and unchecked. Healthcare is a heavily regulated industry—this bill would exempt one favored practice area from basic safety standards because their works furthers an ideological preference.

According to Section 2(a)(9), nearly 500 state laws to regulate abortion have been passed since 2011. This year, at least 21 states have enacted restrictions on abortion. This Act seeks to invalidate many of them. The argument that abortion is a constitutionally protected right and therefore must be protected by the federal government means States would have virtually no say in enacting abortion laws. This bill pushes federal power over the power given to the States.

As if stripping many robust protections from existing state law is not enough, the Act also prohibits regulations of abortion providers that could be considered a restriction on an individual from having an abortion. The Act thereby engenders a regulatory regime that is akin to the one in Pennsylvania that allowed the infamous abortion provider, Kermit Gosnell, to operate his "House of Horrors" for many years. Gosnell, who was ultimately convicted of involuntary manslaughter, was able to provide unsafe, unsanitary, and deadly abortions for many years because, according to the Grand Jury report, the Pennsylvania Department of Health thought it could not inspect or regulate abortion clinics because that would interfere with access to abortion.[70] By lowering professional accountability, abortion providers will be free to operate without regulation and oversight, to the detriment of women and young girls.[71] If Congress passes the Act, it will turn a blind eye to unsafe abortion practices.

Passing the Act would ultimately create the conditions for Gosnell-like clinics that endanger women seeking abortions. Invalidating a plethora of laws designed to protect women while simultaneously limiting the ability of States to implement remedies in the future a recipe for disaster. This does not improve women's health and is dangerous and wrong.

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[70] *See*, *e.g.*, Conor Friedersdorf, Why Dr. Kermit Gosnell's Trial Should Be a Front-Page Story, ATLANTIC (Apr. 12, 2013), https://www.theatlantic.com/national/archive/2013/04/why-dr-kermit-gosnells-trial-should-be-a-front-pagestory/274944/ (discussing the case of Kermit Gosnell).

[71] *See*, *e.g.*, Ams. United for Life, UNSAFE (3d ed. 2021) (documenting unsafe practices of abortion providers and harm to women's health and safety).

IV. This Act extends far beyond the current mandates of *Roe* and its progeny.

From its inception in *Roe v. Wade*, the abortion "right" has been explicitly qualified. While the Court established a constitutional "right" to abortion, it simultaneously expressed that "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that [ensure] maximum safety for the patient."[72] Affirming what is considered the essential holding of *Roe*, the Supreme Court in *Planned Parenthood v. Casey* asserted that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy. . . . The woman's liberty is not so unlimited, however, that from the outset [of pregnancy] the State cannot show its concern."[73] In both *Casey* and later in *Gonzales v. Carhart*, the Court continued to affirm its "essential holding" that States have "legitimate interests from the outset of the pregnancy in protecting the health of the woman."[74] This means the States can enact regulations aimed at protecting the health of the mother from the earliest stages of pregnancy.

Over the past five decades, the Supreme Court has, at various points, yielded back authority to the States, recognizing their many important interests in the area of abortion. As recently as 2020, the Supreme Court reverted back to the more permissible *Casey* standard after several years of *Hellerstedt*. The American people, through their elected officials, recognize the need for basic oversight, for genuine informed consent, and for the interests of the child to factor in at some point in pregnancy, even if we disagree on when that is. It is the sponsors of this Act who are out of step with the American people and the biological reality that a preborn child is a member of the human family, not the other way around.

We know abortion is unsafe. Ohio is one of just a handful of states to collect and publicize records on RU-486 "adverse events," a category that ranges from "incomplete abortion/no comment" to emergency transfer for blood transfusions.[75] AUL submitted a public records request for Ohio's chemical abortion adverse events reports (AERs) and received over 400 reports across an 8-year period.[76]

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[72] *Roe*, 410 U.S. at 150.
[73] *Casey*, 505 U.S. at 869.
[74] *Id.* at 846; *see also Carhart*, 550 U.S. at 145.
[75] Ohio Reports of RU-486 Events are available to the public under Ohio Sunshine Laws. Records sent to Americans United for Life by the State Med. Board of Ohio Dep't of Health are available upon request or at AUL.org/unsafe.
[76] *Id.*

Every single report recorded a chemical abortion gone wrong. Most included zero follow up information. Many listed "completed surgically" as the outcome (meaning the woman had to go through the emotional and physical burden of a second abortion), while others listed events that required emergency care like "severe bleeding" and "hemorrhage" and "retained products [of conception]."[77] "Retained products of conception (POC)" is medical-speak for when some of the pre-born baby's tissue remains in the uterus and needs to be removed to prevent infection, and it occurs much more frequently after abortion than after completed birth.[78] It is worth noting that this reporting only addresses the physical impact and does not measure the emotional, psychological, or spiritual impacts of taking these drugs and having a chemical abortion.

On October 31, 2019: "Patient took misoprostol incorrectly and failed the abortion. She was sent to Women's Med Center in Dayton, Ohio for a D&C." We *only* have this information because Ohio requires it be collected and made available to the public, and in-person chemical abortion protocol requires a follow up visit. How many more "failed abortions" will there be when abortionists wash their hands of responsibility and leave women to fend for themselves? How many more "failed abortions" would there be if all fifty states recorded and shared this information? How many fewer if the Act prohibits States from collecting and publicizing basic reporting data? Removing abortion from the medical context increases the likelihood of complications and adverse events while simultaneously signaling to women that this is their problem to solve alone.

The "right" to abortion in this country has never been unqualified or unregulated as this bill would require. Even in the years immediately after *Roe* before states began reinstating basic health and safety frameworks to the abortion industry, there was greater oversight than this bill would permit. Removing every medical component of the abortion procedure in the name of unfettered "access" isn't women's health—it's just abortion.

Conclusion

The outcome of enacting this radical regime of abortion on demand across the country would be devastating. Communities would be unable to act if a Gosnell or

[77] *Id.*
[78] Mark A. Sellmyer et al., *Physiologic, Histologic, and Imaging Features of Retained Products of Conception*, 33 RadioGraphics 3, (May 3, 2013), https://doi.org/10.1148/rg.333125177.

Klopfer set up shop. States would be unable to protect women from bad doctors and unsanitary clinics. Emergency protections and basic informed consent would be stripped away. Women suffering complications would be abandoned, reliant only on emergency rooms with no continuity of care. And complications would increase as the procedure is de-medicalized by doctors who now say they don't even need to see a patient in person or independently verify pregnancy before prescribing chemical abortion pills.

The politicization of this issue is clear in the changes from last Congress' version of the bill. This is not about healthcare, it's not about safety, and it's not about protecting women's—or even "pregnant person's"—health. This bill is about elective abortion on demand without any "barrier", even if that "barrier" is a basic health and safety standard.

Congress expresses policy preferences even in the bills it doesn't pass. This Act says that speedy abortions are valued over women and girls' health and safety. That at no point in pregnancy do the child's interests come into play. That the States, who broadly enact and enforce local healthcare regulations, no longer have a say in this one area of medicine. Congress should once again reject this Act.

Sincerely,

Catherine Glenn Foster
President and CEO
Americans United for Life