United States House of Representatives
Subcommittee on Health of the Committee on Energy and Commerce

Hearing on H.R. 2975, the "Women's Health Protection Act of 2019"
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Prepared Testimony of
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Chairwoman Eshoo, Ranking Member Burgess, and members of the subcommittee, thank you for inviting me here today. My name is Teresa Stanton Collett and I am a professor of law and director of the Prolife Center at the University of St. Thomas School of Law in Minneapolis, Minnesota, where I teach constitutional litigation, property law, and other related courses. I have published numerous articles on the regulation of abortion and authored several amicus curiae briefs on behalf of public officials in cases before the United States Supreme Court, federal courts of appeals, and state supreme courts.

In the past twenty-five years, I have assisted state and federal legislators in evaluating abortion-related legislation, and testified before Congressional and state legislative committees. I also have had the privilege of defending state laws protecting the safety and well-being of women and girls seeking abortions as special assistant attorney general or special counsel in Kansas, New Hampshire, and Oklahoma. My testimony today represents my views as an expert in the area of abortion regulation, and is not intended to represent the views of my employer, the University of St. Thomas, or any other organization or person.

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It is my opinion that the deceptively named "Women's Health Protection Act of 2019", if enacted, would affirmatively harm women, children, and families throughout the country. At the outset, I should note that nowhere in the bill is there any acknowledgement that elective abortions are almost always performed on healthy women with healthy pregnancies. All of the procedures identified in Section 2 (a) (4) of H.R. 2975, with the exception of a vasectomy, are procedures to diagnose or treat a disease or infirmity. Therefore, they are fundamentally different from abortion, which ends the life of a whole, separate, unique, living human being.[1] Preemption of all state laws regulating the practice of abortion as required by H.R. 2975 would be an extraordinary and deeply divisive act, which effectively disenfranchises every American citizen who believes that we have an obligation to protect both women and children –whether the children are born or unborn.

In my brief time before this subcommittee, I would like to make three key points regarding H.R. 2975: 1) there is no evidence that access to abortion facilitates women's participation in the economic and social life of the country; 2) increasing state regulation is not the cause of declining abortion access; and 3) H.R. 2975 would eliminate hundreds of laws that protect women and girls from malpractice by abortion providers and misconduct by others.

1. There is little to no correlation or causation between women's participation in the economic and social life of the United States and abortion access.

A central premise of H.R. 2975 is that unregulated abortion is a necessary precondition to "women's ability to participate equally in the economic and social life of the United States." This is a demonstrably false statement, notwithstanding its similarity to a sentiment expressed in the

[1] *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 530 F.3d 724, 735–36 (8th Cir. 2008) (*en banc*).

three-justice plurality opinion in *Planned Parenthood of S.E. Penn. v. Casey*, 505 U.S. 833 (1992).[2] At the time the justices authored the plurality opinion, abortion rates had already begun what has become a steady decline in the United States.

In every single year from 1991 to 2016, abortion declined both in terms of absolute numbers and in ratios. In 1991, there were nearly 1.4 million abortions (338 for every 1,000 live births, and 24 per 1,000 women of reproductive age). By 2016, the federal government reported 623,471 abortions (186 for every 1,000 live births, and 11.6 per every 1,000 women of reproductive age).[3] During that same time, however, participation in the labor force by women remained relatively steady, fluctuating from 60.1% in 1991 (53.7% employed, 6.4% unemployed) to a high in 2000 of 61.6 % (57.5 % employed, 4.1% unemployed) to 58.9% in 2016 (54.1% employed, 4.8 unemployed), the latest year for which we have CDC data on abortion rates.[4] The growth of labor force participation for women with children under age 18 has also remained relatively steady when compared with the dramatic declines in abortion rates. Their participation grew from about 66.6% employed in 1991 to 70.2% employed in 1996, peaking at 72.9% employed in 2000, retreating to 70.8% employed in 2016, then beginning a gradual climb to about 71.4% employed where it is currently.[5] It is clear that over the past three decades during which

[2] "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." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 856 (1992) (plurality op.).
[3] Jatlaoui TC, Eckhaus L, Mandel MG, et al. Abortion Surveillance — United States, 2016. MMWR Surveill Summ 2019;68(No. SS-11):1–41. DOI: http://dx.doi.org/10.15585/mmwr.ss6811a1
[4] U. S. Dept of Labor, Bureau of Labor Statistics, Women in the labor force: a databook, Dec. 2019 (Table 2 Employment Status of the civilian noninstitutional population, 16 years and older, by gender, 1948- 2018) https://www.bls.gov/opub/reports/womens-databook/2018/pdf/home.pdf.
[5] U. S. Dept. of Labor, Bureau of Labor Statistics, Women in the labor force: a databook, Dec. 2019 (Table 7 Women's Employment Status by presence and age of children, March 1975 to March 2018) https://www.bls.gov/opub/reports/womens-databook/2018/pdf/home.pdf.

abortion rates and numbers have dramatically declined, women's access to the economic life of the country has held steady.

Similarly, the dramatic growth in women-owned business is independent of trends in abortion access and rates. "The share women-owned businesses represent of all businesses has skyrocketed from a mere 4.6% in 1972 to 42% in 2019."[6] In 2019 these businesses represented "42% of all businesses — nearly 13 million — employing 9.4 million workers and generating revenue of $1.9 trillion."[7]

The U.S. Census Bureau graphic of the growth of women-owned businesses from 1997 to 2012, a time during which abortions ratios and rates declined almost one-third illustrates the lack of correlation between women's entrepreneurship and abortion access. In 1997 the national abortion ratio was 306 legal induced abortions per 1,000 live births, with an abortion rate of 20 per 1,000 women aged 15--44 years.[8] In 2012, the abortion ratio was 210 abortions per 1,000 live births with a rate of 13.2 abortions per 1,000 women aged 15–44 years.[9]

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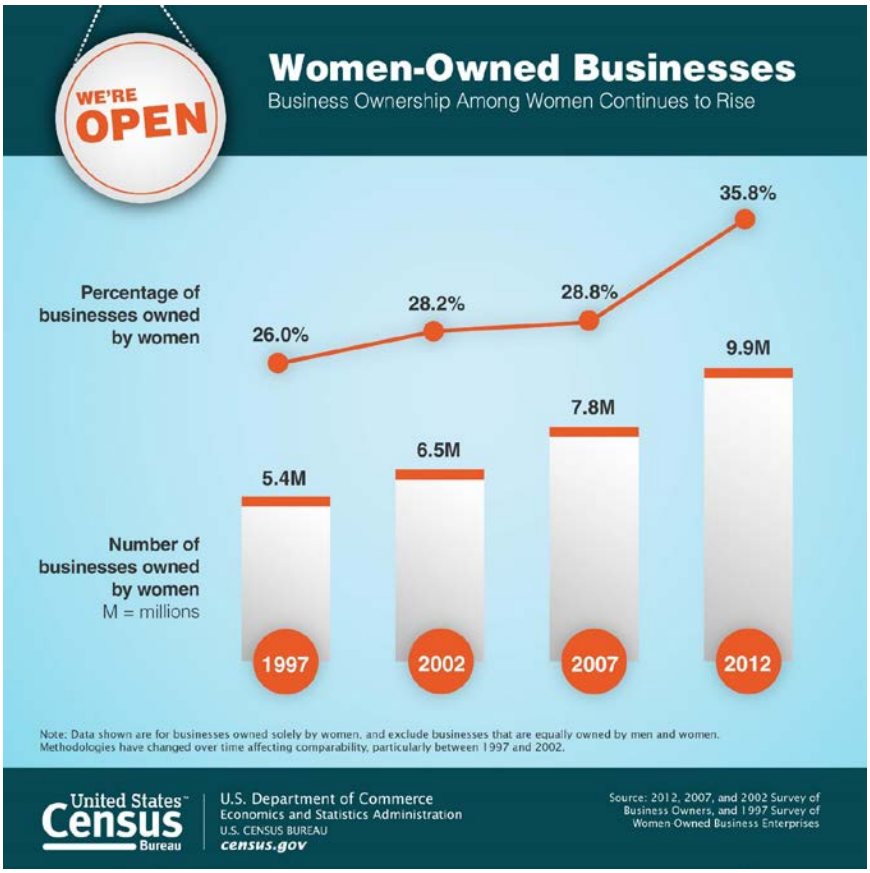
[6] American Express, The 2019 State of Women-Owned Businesses Report at 3, https://about.americanexpress.com/files/doc_library/file/2019-state-of-women-owned-businesses-report.pdf.

[7] Id. at 15.

[8] Koonin, L. et al., Abortion Surveillance --- United States, 1997, MMRW Surveillance Summaries, Dec. 8, 2000 / 49(SS11); 1-44 at https://www.cdc.gov/mmwr/preview/mmwrhtml/ssDecember 08, 2000 / 49(SS11);1-444911a1.htm. In 2002, there were 246 legally induced abortions per 1,000 live births, with an abortion rate of 16 per 1,000 women aged 15--44 years. In 2007, the abortion rate was 16.0 abortions per 1,000 women aged 15--44 years, and the abortion ratio was 231 abortions per 1,000 live births. Pazol, K. et al., Abortion Surveillance --- United States, 2007, MMRW Surveillance Summaries, Feb. 25, 2011 / 60(SS01);1-39 at https://www.cdc.gov/mmwr/preview/mmwrhtml/ss6001a1.htm.

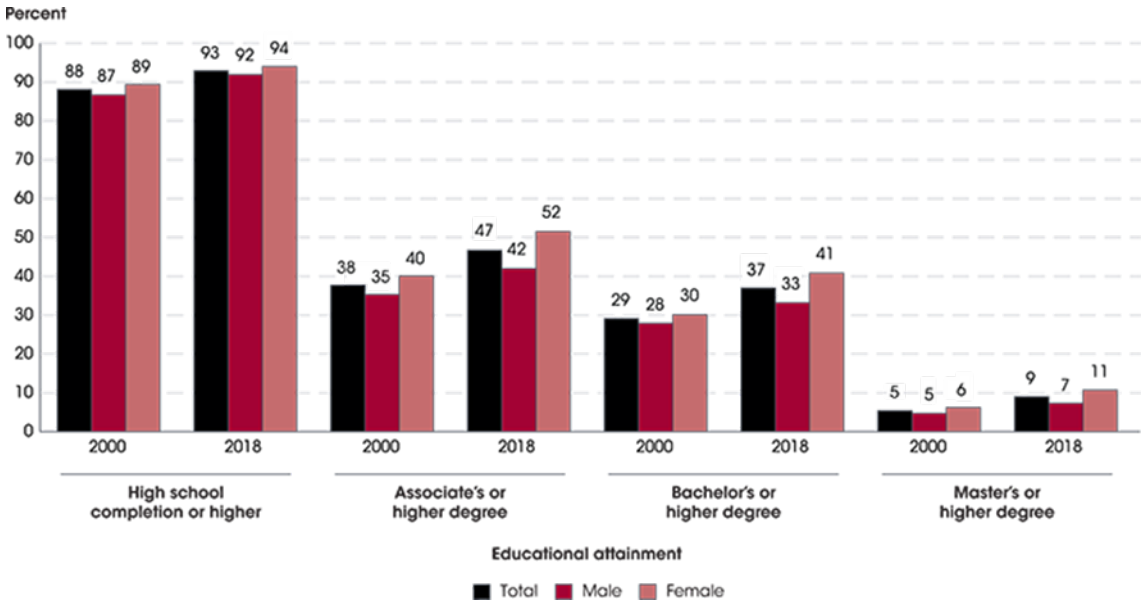
[9] Pazol, K. et al., Abortion Surveillance --- United States, 2012, MMRW Surveillance Summaries, Nov. 27. 2015 / 64(SS10);1-40 at https://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410A1.htm.



To the extent there is any correlation between abortion access and entrepreneurial activity by women, one could argue that entrepreneurship increases if abortion declines, but I will not insult the intelligence of committee members by making this claim. Instead, I will simply note that in the absence of correlation, there is no evidence that access to abortion increases women's entrepreneurial activities.

Let me offer one more example to persuade you of my conclusions. In addition to providing general statistics about labor force participation, the U.S. Bureau of Labor Statistics' databook on Women's Participation in the Labor Force summarizes women's educational achievements in the years between 1970 and 2018. "[F]rom 1970 to 2018, the proportion of women ages 25 to 64 in the labor force who held a college degree quadrupled, whereas the proportion of men with a college

degree about doubled over that time."[10] Data from the National Center for Education Statistics provides a historical view of women's progress. The chart below shows the educational gains that women have made in the past two decades. [11]



In 1991 women achieved parity with men regarding the completion of four years of college. Today, when abortion rates are about less than half of the 1991 figures, 8% more American women are annually completing a four-year college education, and women in the United States are now generally more likely than men to have some form of a college degree.

The data shows that it simply is not true that "[a]ccess to safe, legal abortion services is . . . central to women's ability to participate equally in the economic and social life of the United States." H.R. 2975, Sec. 2 (a) (1).

[10] U. S. Dept. of Labor, Bureau of Labor Statistics, Women in the labor force: a databook, Dec. 2019 at 1, https://www.bls.gov/opub/reports/womens-databook/2018/pdf/home.pdf.
[11] National center for Education Statistics, Educational Attainment of Young Adults (May 2019), https://nces.ed.gov/programs/coe/indicator_caa.asp.

2. State regulation is not the cause of declining access to abortion.

Just as empirical evidence does not support the first Congressional Finding in H.R. 2975; it does not support claims that clinic closures are primarily the product of state regulation. Researchers have acknowledged they are only able to speculate as to the reasons for the sharp decline in abortion rates over the past three decades.

> Between 2011 and 2017, the number of clinics providing abortion in the U.S. declined from 839 to 808, with significant regional disparities, the report said. The South had a decline of 50 clinics, including 25 in Texas, and the Midwest had a decline of 33 clinics, including nine each in Iowa, Michigan and Ohio. By contrast, the Northeast added 59 clinics, mostly in New Jersey and New York.
>
> Over that period, the abortion rate dropped in Ohio by 27 percent and in Texas by 30 percent, but the rate dropped by similar amounts in states that protected abortion access, including California, Hawaii and New Hampshire.[12]

A plausible explanation of this lack of correlation is the restructuring of the abortion industry.

Shrinking markets, like that for abortion services, require businesses to embrace economies of scale and cost efficiency to survive. As I explained in my symposium contribution to SCOTUSblog prior to the U.S. Supreme Court rendering its decision in *Whole Woman's Health v. Hellerstedt*, 579 U.S. ___ (2016):

> Planned Parenthood, both nationally and in Texas, is aggressively increasing its market share through the creation of "mega-clinics," making it difficult if not impossible for independent providers to compete. In 2010, Planned Parenthood opened a new 78,000-square-foot facility in Houston. According to a May 20, 2010 article in the Houston Chronicle, the new facility provided "room to increase Texas clients by 30 percent, from 90,000 visits to those 10 locations in 2009 to roughly 120,000 annually." In 2014, Planned Parenthood in San Antonio opened a new 22,000-square-foot facility. Planned Parenthood Affiliate President Jeffery Hons told the local newspaper that the new center will perform about 2,800 abortions a year — an increase of 1,000 over the number provided two years ago, before HB 2." That is an increase of 30,000 visits in Houston plus 1,000 new abortions performed in San Antonio. This sort of increase in capacity makes

[12] Associated Press, U.S. NEWS, Number of abortions in U.S. drops to lowest since they became legal nationwide, report finds, NBC News, Sept. 18, 2019 at https://www.nbcnews.com/news/us-news/number-abortions-u-s-drops-lowest-they-became-legal-nationwide-n1055726.

> continued existence of small competitors more difficult regardless of the regulatory environment. [13]

Like the claim that access to abortion is necessary for women to fully participate in the economic and social life of the country, the evidence does not establish that clinic closures are primarily due to increasing state regulation.

Proponents of abortion on demand seek to avoid this inconvenient fact by citing long travel distances to clinics and the absence of providers in rural areas, ignoring the fact that abortion is not unique in this. As of 2014, 54% of rural counties did not have a hospital with obstetrics services. [14] Researchers at the nonpartisan Center for Studying Health System Change have found that "[t]wenty-one percent of patient deaths or permanent injuries related to ED [emergency department] treatment delays are attributed to lack of availability of physician specialists" and "[t]wo-thirds of ED directors in level I and II trauma centers say that more than half of all patient transfers they receive stem from lack of timely access to specialist physicians at the referring hospital." The practical implications of the absence of emergency medical personnel are concisely stated by Gary Hart, PhD, director of the Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, in Grand Forks. "Greater distances also result in longer

[13] Teresa Collett, *Symposium: Ensuring abortion safety in a declining market for abortion services*, SCOTUSBLOG (Jan. 7, 2016, 9:43 AM), https://www.scotusblog.com/2016/01/symposium-ensuring-abortion-safety-in-a-declining-market-for-abortion-services/. *See also* Willis Krumholz, *How to Make Abortion Less Profitable*, at https://thefederalist.com/2020/01/24/how-to-make-abortion-less-profitable-for-planned-parenthood/.

[14] Hung, P. *et al., Access To Obstetric Services In Rural Counties Still Declining, With 9 Percent Losing Services, 2004–14*, Health Affairs, September 2017 at https://www.healthaffairs.org/doi/citedby/10.1377/hlthaff.2017.0338.

wait times for rural emergency medical services (EMS). That can endanger patients requiring EMS treatment. "If you're bleeding, in that extra 15 minutes (before help arrives), you can die."[15]

The difficulties in accessing abortion services in rural areas is not the result of state regulation of abortion. It is the result of market forces in areas where demand and payment for services does not equal the cost of providing those services. Like many other industries, the abortion industry is undergoing structural changes to adapt to declining markets. There simply is no factual basis for the deregulation of the industry by federal fiat as proposed in H.R. 2975.

3. H.R. 2975 would eliminate hundreds of laws that protect women and girls from malpractice by abortion providers and misconduct by others.

While the abortion industry consistently promotes the idea that abortion is one of the safest medical procedures in the United States, the evidence offered to support that claim is typically research conducted by proponents of abortion. H.R. 2975, Sec. 2 (a) (5) specifically cites the work of the National Abortion Federation ("NAF") and the American College of Obstetricians and Gynecologists. NAF's domestic membership is described on the organization's webpage as "private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, and hospitals who together care for approximately half the women who choose abortion in the U.S. and Canada each year."[16] As an industry trade group, the organization does not even pretend to neutrally evaluate the need for legal regulation of abortion. Similarly, the history of

[15] Warshaw, R., *Health Disparities Affect Millions in Rural U.S. Communities* (Oct. 31, 2017) at https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities.
[16] https://prochoice.org/about-naf/

abortion advocacy by the American College of Obstetricians and Gynecologists renders its conclusions regarding the safety of abortion and the need for legal regulations suspect.[17]

The impact of biases on the design of medical research, the gathering and interpretation of data, and suppression of contrary opinions has been well documented.[18] Dr. Marcia Angell, a former editor-in-chief of the New England Journal of Medicine, has publically noted two troubling aspects of bias in the context of medical research.

> There's good evidence that drug company involvement biases research in ways that are not always obvious, often by suppressing negative results. A review of 74 clinical trials of antidepressants, for example, found that 37 of 38 positive studies — that is, studies that showed that a drug was effective — were published. But 33 of 36 negative studies were either not published or published in a form that conveyed a positive outcome.[19]

This is true because generally researchers have no obligation to publish the results of any research, nor are there effective sanctions for refusing to share research data with other investigators, particularly investigators that do not share the biases of the original researcher.

Dr. Angell also notes, "Bias can also be introduced through the design of a clinical trial. For example, the sponsor's drug may be compared with another drug administered at a dose so low that the sponsor's drug looks more powerful. Or it can be compared with a placebo, when the relevant question is how it compares with an existing drug. In short, it's often possible to make clinical trials come out the way you and your sponsors want."[20]

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[17] Brief of *Amicus Curiae* American Association of Pro-life Obstetricians and Gynecologists in Support of Rebekah Gee, Secretary, Louisiana Dept. of Health and Hospitals, June Medical Services L.L.C. v. Gee, 2019 WL 7397763 at 5 (U.S. 2019).

[18] Koehler JJ. The influence of prior beliefs on scientific judgments of evidence quality. Organ. Behav. Hum. Decis. Process 1993; 56(1): 28–55.

[19] Angell, M., *Transparency Hasn't Stopped Drug Companies From Corrupting Medical Research*, New York Times Sept. 17, 2018, Section A, Page 21 at https://www.nytimes.com/2018/09/14/opinion/jose-baselga-research-disclosure-bias.html

[20] *Id*.

Given the virtual monopoly the abortion industry has over access to data related to women seeking and obtaining abortions, as well as the industry's persistent and pervasive efforts to thwart even the mildest public health reporting requirements,[21] the ability to assess accurately the safety and impact of abortion on women is limited. Providers have even gone so far as to challenge requirements that they provide information regarding pregnancies resulting from sexual assaults on minors.[22]

In cases where malpractice or misconduct exists and is known to public officials, there is often no political will to prosecute,[23] or abortion providers obtain overly broad protective orders, denying the public information regarding clinic practices and safety.

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[21] The Supreme Court has resolved to some of these challenges. For example, in *Planned Parenthood v. Casey*, the abortion provider challenged the requirement that "For each abortion performed, a report must be filed identifying: the physician (and the second physician where required); the facility; the referring physician or agency; the woman's age; the number of prior pregnancies and prior abortions she has had; gestational age; the type of abortion procedure; the date of the abortion; whether there were any pre-existing medical conditions which would complicate pregnancy; medical complications with the abortion; where applicable, the basis for the determination that the abortion was medically necessary; the weight of the aborted fetus; and whether the woman was married, and if so, whether notice was provided or the basis for the failure to give notice." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 900 (Pa., 1992).

[22] *E.g. Manning v. Hunt*, 119 F.3d 254, 273 (4th Cir. 1997) (attacking requirement that judges report sexual abuse of minors seeking judicial bypass of parental involvement in abortion decision). The court in the *Manning* case characterized plaintiffs position as "unconscionable" and "untenable", ultimately rejecting it on the basis that "Appellants' position prevent the judge from helping the victim seeking the abortion, but it would prevent the judge from helping other juveniles in the same household under the same threat of incest."), and *Aid for Women v. Foulston*, 441 F.3d 1101, 1120 (10th Cir. 2006) (privacy rights of minors are diminished when the activity is criminal).

[23] In the infamous case of Kermit Gosnell, the Grand Jury specifically found:

> [T]he Pennsylvania Department of Health abruptly decided, for political reasons, to stop inspecting abortion clinics at all. The politics in question were not anti-abortion, but pro. With the change of administration from Governor Casey to Governor Ridge, officials concluded that inspections would be "putting a barrier up to women" seeking abortions. Better to leave clinics to do as they pleased, even though, as Gosnell proved, that meant both women and babies would pay."

June Medical Services v. Gee, a case currently pending before the Supreme Court, involves just such an order. In ruling on the transmission of protected materials contained in the trial record to reviewing courts, Judge Jennifer Elrod noted:

> Plaintiffs have worked to prevent investigation and prosecution of lawbreaking that harms abortion patients. Earlier this year, in a deposition in the June II litigation, Doe 2 testified "Doe 5[] violates the standard of care for second-trimester abortions." See In re Gee, No. 19-30953 at 6 (Elrod, J., concurring) available at http://www.agjefflandry.com/Files/Article/9726/Documents/FifthCircuitOrder.pdf . Doe 2's testimony also suggests he committed crimes in connection with his abortion practice, including failure to report the rape of a 14-year-old girl and knowingly performing an abortion on another minor without parental consent or a judicial bypass. Id. at 6-7.20 Louisiana sought leave to disclose that information to law enforcement and professional disciplinary authorities, but the June II plaintiffs (Hope and Does 1, 2, and 3) opposed, thus placing their own professional and litigation interests ahead of Louisiana women.[24]

This sort of secrecy by the industry undercuts the credibility of abortion advocates' claims related both to the safety of the practice and the professionalism of its practitioners.

Allow me one more example of the harm that H.R. 2975 will do by its attempt to preempt nearly all state regulation of abortions. States play an important role in our federalist form of government. They are closer to the people and more flexible when adapting to the specific needs and issues that face their residents. In the constitutional order, our federal government is one of

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In re County Investigating Grand Jury XXIII, Misc. No. 0009901-2008, Ct. of Common Pleas, First Judicial Dist. of PA, Crim. Trial Div. (2011) at 9, https://cdn.cnsnews.com/documents/Gosnell,%20Grand%20Jury%20Report.pdf.

In 2013, Dr. Gosnell was convicted of three counts of first-degree murder for by severing the spinal cords of infants born alive during failed abortions, one count of involuntary manslaughter in the death of a patient who was overdosed by his untrained staff, and twenty-one counts of performing illegal abortions on women who were more than twenty-four weeks pregnant. *Commonwealth v. Gosnell*, No. CP-51-CR-0001667-2011 (Pa. Ct. Com. Pl., Phila. County May 15, 2013).

[24] Brief for the Respondent/Cross-Petitioner, *June Medical Services L.L.C. v. Gee*, 2019 WL 7372920 at 46-47 (U.S. 2019).

limited powers, while state governments have plenary powers, including the police power to legislate for the health, safety, morals and general welfare of their residents.

If enacted, H.R. 2975 would preempt state legislation designed to protect against sex trafficking and the commercial exploitation of young girls and women. Sex trafficking has reached epidemic proportions in the United States. Reports show that sex trafficking continues to grow year over year.[25] Not only does sex trafficking disproportionately affect girls and women of color, but it also targets vulnerable immigrants. An estimated 17,000 foreign nationals are trafficked into the United States each year.[26] Abortion and sex trafficking are inextricably linked. One paper summarizing the prevalence of forced abortions in sex trafficking, revealed, for example, that in a study of 66 sex-trafficked women, the women had a total of 114 abortions, nearly two for every sex trafficking survivor.[27]

Many states have addressed the issue of forced abortions and sex trafficking by passing parental notification laws and mandatory reporting laws.[28] The Supreme Court has found these types of laws constitutional.[29] Thus, the issue before this committee is not whether a state can

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[25] *See* Polaris, *2018 Statistics from the National Human Trafficking Hotline* p.3, available at https://polarisproject.org/wp-content/uploads/2019/09/Polaris_National_Hotline_2018_Statistics_Fact_Sheet.pdf.

[26] See FAIR, *Human Trafficking—Exploitation of Illegal Aliens*, available at https://www.fairus.org/issue/illegal-immigration/human-trafficking-exploitation-illegal-aliens.

[27] Laura J. Lederer and Christopher A. Wetzel, *The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities*, 23 Annals of Health Law 61, 73 (2014), available at https://www.globalcenturion.org/wp-content/uploads/2014/08/The-Health-Consequences-of-Sex-Trafficking.pdf.

[28] Another example are laws that protect against sex trafficking are those that require reporting to law enforcement victims of sex trafficking and minors seeking abortions. *See, e.g.*, La. R.S. 40:2175.7.

[29] *E.g. Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992) (plurality op.).

constitutionally protect women from forced abortions; they can, but rather whether it is good policy for Congress to eviscerate these protections through this proposed legislation.

This is only one area where state legislation advances its interests to protects the state's citizens. Many state regulations ensure adequate facilities and qualifications for those performing abortion procedures. Abortion clinics have a profit incentive to provide as many abortions as possible, with the least amount of regulation. This proposed bill will eliminate or severely limit a state's ability to identify and stop sexual trafficking and exploitation when that exploitation includes coerced abortions. Instead of creating a law that will overturn these protections, Congress should be looking for solutions that support states' efforts to find and root out such crimes.

Conclusion

I am opposed to this act because it is based on industry slogans, not fact; it is bad public policy; and it hinders a state's duty to protect its citizens, including, as discussed today, from sex trafficking and exploitation. I urge members of this committee to vote against its passage.

Thank you, Chairwoman Eshoo, for allowing me to appear before your committee, and submit written testimony.