To protect a woman’s ability to determine whether and when to bear a child or end a pregnancy, and to protect a health care provider’s ability to provide reproductive health care services, including abortion services.
Mr. O’Halleran, Ms. Omar, Mr. Panetta, Mr. Pappas, Mr. Payne, Mr. Perlmutter, Mr. Peters, Ms. Pingree, Mr. Pocan, Ms. Pressley, Mr. Price of North Carolina, Mr. Quigley, Mr. Raskin, Miss Rice of New York, Mr. Richmond, Mr. Rouda, Mr. Ruppersberger, Ms. Sánchez, Mr. Sarbanes, Ms. Schakowsky, Mr. Schiff, Mr. Schneider, Mr. Schrader, Ms. Schrier, Mr. Serrano, Ms. Shalala, Mr. Shires, Mr. Smith of Washington, Mr. Soto, Ms. Speier, Mr. Swalwell of California, Mr. Takano, Mr. Thompson of California, Ms. Titus, Mr. Trone, Ms. Traian, Mr. Tonko, Mrs. Torres of California, Mrs. Trahan, Mr. Huffman, Mr. Garamendi, Mr. McGovern, Ms. Porter, Mr. Case, Ms. Ocasio-Cortez, Mr. Cicilline, Mr. Gallego, Mr. Brendan F. Boyle of Pennsylvania, Mr. García of Illinois, Ms. Sherrill, Mr. David Scott of Georgia, and Mr. DeSaulnier) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL
To protect a woman’s ability to determine whether and when to bear a child or end a pregnancy, and to protect a health care provider’s ability to provide reproductive health care services, including abortion services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.
This Act may be cited as the “Women’s Health Protection Act of 2019”.

SEC. 2. FINDINGS AND PURPOSE.
(a) FINDINGS.—Congress finds the following:
(1) Access to safe, legal abortion services is essential to women’s health and central to women’s ability to participate equally in the economic and social life of the United States.
(2) Since 1973, the Supreme Court repeatedly has recognized the constitutional right of a woman to decide to terminate her pregnancy before fetal viability, and to terminate her pregnancy after fetal viability where it is necessary, in the good-faith medical judgment of the treating health care professional, for the preservation of her life or health.

(3) Nonetheless, access to safe, legal abortion services has been hindered across the United States in various ways, including blockades of health care facilities and associated violence, prohibitions of and restrictions on insurance coverage, restrictions which shame and stigmatize women seeking abortion services, and medically unnecessary regulations which neither confer any health benefit nor further the safety of abortion services, but which harm women by delaying access to, and reducing the availability of, services. Since 2010, States and local governments have passed more than 400 such restrictions singling out health care providers who offer abortion services and interfering with health care providers’ ability to provide reproductive health care services and the ability of patients to obtain those services.

(4) Many State and local governments have imposed restrictions on the provision of abortion that
are neither evidence-based nor generally applicable to the medical profession or to other medically comparable outpatient gynecological procedures, such as endometrial ablations, dilation and curettage for reasons other than abortion, hysteroscopies, loop electrosurgical excision procedures, or other analogous non-gynecological procedures performed in similar outpatient settings including vasectomy, sigmoidoscopy, and colonoscopy.

(5) Legal abortion is one of the safest medical procedures in the United States. An independent review of research on the safety and quality of abortion services in the United States, published by the National Academies of Sciences, Engineering, and Medicine in 2018, found that abortion in all forms is safe and effective and that the biggest threats to the quality of abortion services in the United States are State regulations that create barriers to care. These abortion-specific restrictions conflict with medical standards and are not supported by the recommendations and guidelines issued by leading reproductive health care professional organizations including the American College of Obstetricians and Gynecologists, the Society of Family Planning, the
National Abortion Federation, the World Health Organization, and others.

(6) Many abortion-specific restrictions do not confer any health or safety benefits on the patient. Instead, these restrictions have the purpose and effect of unduly burdening women’s personal and private medical decisions to end their pregnancies by making access to abortion services more difficult, invasive, and costly, forcing women to travel significant distances and make multiple unnecessary visits to the provider, and in some cases, foreclosing the option altogether. For example, a 2018 report from the University of California San Francisco’s Advancing New Standards in Reproductive Health research group found that in 27 cities across the United States, people have to travel more than 100 miles in any direction to reach an abortion provider.

(7) These restrictions additionally harm women’s health by reducing access not only to abortion services but also to the other essential health care services offered by the providers targeted by the restrictions, including—

(A) contraceptive services, which advance women’s health and provide a range of benefits,
including preventing unintended pregnancies
and reducing the need for abortion; and

(B) screenings for cervical cancer and sexually transmitted infections.

(8) The cumulative effect of these numerous restrictions has been to severely limit the availability of abortion services in some areas, creating a patchwork system where access to abortion services is more available in some States than in others. A 2019 report from the Government Accountability Office examining State Medicaid compliance with abortion coverage requirements analyzed 7 key challenges (identified both by health care providers and research literature) and their effect on abortion access, and found that access to abortion services varied across the States and even within a State.

(9) The harms of these abortion-specific restrictions fall especially heavily on low-income women, women of color, immigrants, young people, and women living in rural and other medically underserved areas.

(10) Abortion-specific restrictions single out health services used by women, and rely on and reinforce stereotypes about women’s roles, women’s decisionmaking, and women’s need for protection. These
restrictions harm the basic autonomy, dignity, equality, and ability of women to participate in the social and economic life of the Nation.

(11) Not all people who become pregnant or need abortion services identify as women. Access to abortion services is critical to the health of every person regardless of actual or perceived race, color, national origin, immigration status, sex (including gender identity, sex stereotyping, or sexual orientation), age, or disability status. This Act’s protection is inclusive of all pregnant people.

(12) These restrictions affect the cost and availability of abortion services, and the settings in which abortion services are delivered. Women travel across State lines and otherwise engage in interstate commerce to access this important medical care, and more would be forced to do so absent this Act. Likewise, health care providers travel across State lines and otherwise engage in interstate commerce in order to provide reproductive health services to patients, and more would be forced to do so absent this Act.

(13) Health care providers, including those who provide abortion services, engage in a form of economic and commercial activity when they provide
abortion services, and there is an interstate market for abortion services.

(14) To provide abortion services, health care providers engage in interstate commerce to purchase medicine, medical equipment, and other necessary goods and services. To provide and assist others in providing abortion services, health care providers engage in interstate commerce to obtain and provide training. To provide abortion services, health care providers employ and obtain commercial services from doctors, nurses, and other personnel who engage in interstate commerce and travel across State lines. Abortion restrictions substantially affect interstate commerce in numerous ways.

(15) It is difficult and time-consuming for clinics to challenge State laws that burden or impede abortion services. Litigation that blocks one abortion restriction may not prevent a State from adopting other abortion restrictions or using different methods to burden or impede abortion services. There is a history and pattern of States passing successive and different laws that impede and unduly burden abortion services.

(16) When a health care provider ceases providing abortion services as a result of burdensome
and medically unnecessary regulations, it is often
difficult or impossible for that health care provider
to recommence providing those abortion services,
and difficult or impossible for other health care pro-
viders to provide abortion services that restore or re-
place the ceased abortion services.

(17) An overwhelming majority of abortions in
the United States are provided in clinics, not hos-
pitals. The large majority of United States counties
have no clinics that provide abortion.

(18) Congress has the authority to enact this
Act to protect abortion services pursuant to—

(A) its powers under the commerce clause
of section 8 of article I of the Constitution of
the United States;

(B) its powers under section 5 of the Four-
teenth Amendment to the Constitution of the
United States to enforce the provisions of sec-
tion 1 of the Fourteenth Amendment; and

(C) its powers under the necessary and
proper clause of section 8 of Article I of the
Constitution of the United States.

(19) Congress has used its authority in the past
to protect women’s ability to access abortion services
and health care providers’ ability to provide abortion
services. In the early 1990s, protests and blockades at health care facilities where abortion services were provided, and associated violence, increased dramatically and reached crisis level, requiring Congressional action. Congress passed the Freedom of Access to Clinic Entrances Act (Public Law 103–259; 108 Stat. 694) to address that situation and protect physical access to abortion services.

(20) Congressional action is necessary to put an end to harmful restrictions, to federally protect access to abortion services for all women regardless of where they live, and to protect the ability of reproductive health care providers to provide these services in a safe and accessible manner.

(b) PURPOSE.—It is the purpose of this Act—

(1) to permit health care providers to provide abortion services without limitations or requirements that single out the provision of abortion services for restrictions that are more burdensome than those restrictions imposed on medically comparable procedures, do not significantly advance women’s health or the safety of abortion services, and make abortion services more difficult to access;
(2) to promote women’s health and women’s ability to participate equally in the economic and social life of the United States; and

(3) to invoke Congressional authority, including the powers of Congress under the commerce clause of section 8 of article I of the Constitution of the United States, its powers under section 5 of the Fourteenth Amendment to the Constitution of the United States to enforce the provisions of section 1 of the Fourteenth Amendment, and its powers under the necessary and proper clause of section 8 of article I of the Constitution of the United States.

SEC. 3. DEFINITIONS.

In this Act:

(1) ABORTION SERVICES.—The term “abortion services” means an abortion and any medical or non-medical services related to and provided in conjunction with an abortion (whether or not provided at the same time or on the same day as the abortion).

(2) HEALTH CARE PROVIDER.—The term “health care provider” means any entity or individual (including any physician, certified nurse-midwife, nurse practitioner, and physician assistant) that is—
(A) engaged in the delivery of health care services, including abortion services; and

(B) if required by law or regulation to be licensed or certified to engage in the delivery of such services, is so licensed or certified.

(3) MEDICALLY COMPARABLE PROCEDURES.—

The term “medically comparable procedures” means medical procedures that are similar in terms of health and safety risks to the patient, complexity, or the clinical setting that is indicated.

(4) PREGNANCY.—The term “pregnancy” refers to the period of the human reproductive process beginning with the implantation of a fertilized egg.

(5) VIABILITY.—The term “viability” means the point in a pregnancy at which, in the good-faith medical judgment of the treating health care provider, based on the particular facts of the case before the health care provider, there is a reasonable likelihood of sustained fetal survival outside the uterus with or without artificial support.

SEC. 4. PERMITTED SERVICES.

(a) GENERAL RULE.—A health care provider has a statutory right under this Act to provide abortion services, and may provide abortion services, and that provider’s pa-
tient has a corresponding right to receive such services, without any of the following limitations or requirements:

(1) A requirement that a health care provider perform specific tests or medical procedures in connection with the provision of abortion services, unless generally required for the provision of medically comparable procedures.

(2) A requirement that the same health care provider who provides abortion services also perform specified tests, services, or procedures prior to or subsequent to the abortion.

(3) A requirement that a health care provider offer or provide the patient seeking abortion services medically inaccurate information in advance of or during abortion services.

(4) A limitation on a health care provider’s ability to prescribe or dispense drugs based on current evidence-based regimens or the provider’s good-faith medical judgment, other than a limitation generally applicable to the medical profession.

(5) A limitation on a health care provider’s ability to provide abortion services via telemedicine, other than a limitation generally applicable to the provision of medical services via telemedicine.
(6) A requirement or limitation concerning the physical plant, equipment, staffing, or hospital transfer arrangements of facilities where abortion services are provided, or the credentials or hospital privileges or status of personnel at such facilities, that is not imposed on facilities or the personnel of facilities where medically comparable procedures are performed.

(7) A requirement that, prior to obtaining an abortion, a patient make one or more medically unnecessary in-person visits to the provider of abortion services or to any individual or entity that does not provide abortion services.

(8) A prohibition on abortion prior to fetal viability, including a prohibition or restriction on a particular abortion procedure.

(9) A prohibition on abortion after fetal viability when, in the good-faith medical judgment of the treating health care provider, continuation of the pregnancy would pose a risk to the pregnant patient’s life or health.

(10) A limitation on a health care provider’s ability to provide immediate abortion services when that health care provider believes, based on the
good-faith medical judgment of the provider, that
delay would pose a risk to the patient’s health.

(11) A requirement that a patient seeking abor-
tion services prior to fetal viability state the pa-
tient’s reasons for seeking abortion services, or a
limitation on the provision of abortion services prior
to fetal viability based on the patient’s reasons or
perceived reasons for obtaining abortion services.

(b) Other Limitations or Requirements.—A
health care provider has a statutory right to provide abor-
tion services, and may provide abortion services, and that
provider’s patient has a corresponding right to receive
such services, without a limitation or requirement that—

(1) is the same as or similar to one or more of
the limitations or requirements described in sub-
section (a); or

(2) both—

(A) singles out the provision of abortion
services, health care providers who provide
abortion services, or facilities in which abortion
services are provided; and

(B) impedes access to abortion services
based on one or more of the factors described
in subsection (c).
(c) FACTORS FOR CONSIDERATION.—Factors for a
court to consider in determining whether a limitation or
requirement impedes access to abortion services for pur-
poses of subsection (b)(2)(B) include the following:

(1) Whether the limitation or requirement
interferes with a health care provider’s ability to
provide care and render services in accordance with
the provider’s good-faith medical judgment.

(2) Whether the limitation or requirement is
reasonably likely to delay some patients in accessing
abortion services.

(3) Whether the limitation or requirement is
reasonably likely to directly or indirectly increase the
cost of providing abortion services or the cost for ob-
taining abortion services (including costs associated
with travel, childcare, or time off work).

(4) Whether the limitation or requirement is
reasonably likely to have the effect of necessitating
a trip to the offices of a health care provider that
would not otherwise be required.

(5) Whether the limitation or requirement is
reasonably likely to result in a decrease in the avail-
ability of abortion services in a given State or geo-
graphic region.
(6) Whether the limitation or requirement imposes penalties that are not imposed on other health care providers for comparable conduct or failure to act, or that are more severe than penalties imposed on other health care providers for comparable conduct or failure to act.

(7) The cumulative impact of the limitation or requirement combined with other new or existing limitations or requirements.

(d) EXCEPTION.—To defend against a claim that a limitation or requirement violates a health care provider’s or patient’s statutory rights under subsection (b), a party must establish, by clear and convincing evidence, that—

(1) the limitation or requirement significantly advances the safety of abortion services or the health of patients; and

(2) the safety of abortion services or the health of patients cannot be advanced by a less restrictive alternative measure or action.

(e) APPLICABILITY.—

(1) GENERAL RELATIONSHIP TO FEDERAL LAW.—Except as stated in paragraph (2), this Act supersedes and applies to all Federal law, and the implementation of that law, whether statutory or otherwise, and whether adopted before or after the

(2) LIMITATIONS.—The provisions of this Act shall not supersede or apply to—

(A) laws regulating physical access to clinic entrances;

(B) insurance or medical assistance coverage of abortion services;

(C) the procedure described in section 1531(b)(1) of title 18, United States Code; or

(D) generally applicable State contract law.

SEC. 5. RELATIONSHIP TO STATE LAW AND PREEMPTION.

No State, territory, or possession of the United States, or the District of Columbia, or the Commonwealth of Puerto Rico, or subdivision, branch, department, agency, instrumentality, or official (or other person acting under color of law) of any of the foregoing, shall enact or enforce any law, rule, regulation, standard, or other provision having the force and effect of law that conflicts with any provision of this Act.
SEC. 6. EFFECTIVE DATE.

This Act shall take effect immediately upon the date of enactment of this Act. This Act shall apply to all restrictions on the provision of, or access to, abortion services whether the restrictions are enacted or imposed prior to or after the date of enactment of this Act, except as otherwise provided in this Act.

SEC. 7. LIBERAL CONSTRUCTION.

(a) Liberal Construction.—In interpreting the provisions of this Act, a court shall liberally construe such provisions to effectuate the purposes of the Act.

(b) Rule of Construction.—Nothing in this Act shall be construed to authorize any government to interfere with a woman’s ability to terminate her pregnancy, to diminish or in any way negatively affect a woman’s constitutional right to terminate her pregnancy, or to displace any other remedy for violations of the constitutional right to terminate a pregnancy.

SEC. 8. ENFORCEMENT.

(a) Attorney General.—The Attorney General may commence a civil action for prospective injunctive relief on behalf of the United States against any government official that is charged with implementing or enforcing any limitation or requirement that is challenged as a violation of a statutory right under this Act. The court shall hold
unlawful and set aside the limitation or requirement if it is in violation of this Act.

(b) Private Right of Action.—

(1) In general.—Any individual or entity, including any health care provider, aggrieved by an alleged violation of this Act may commence a civil action for prospective injunctive relief against the government official that is charged with implementing or enforcing the limitation or requirement that is challenged as a violation of a statutory right under this Act. The court shall hold unlawful and set aside the limitation or requirement if it is in violation of this Act.

(2) Health care provider.—A health care provider may commence an action for prospective injunctive relief on its own behalf and/or on behalf of the provider’s patients who are or may be adversely affected by an alleged violation of this Act.

(c) Equitable Relief.—In any action under this section, the court may award appropriate equitable relief, including temporary, preliminary, or permanent injunctive relief.

(d) Costs.—In any action under this section, the court shall award costs of litigation, as well as reasonable attorney fees, to any prevailing plaintiff. A plaintiff shall
not be liable to a defendant for costs in any non-frivolous action under this section.

(c) JURISDICTION.—The district courts of the United States shall have jurisdiction over proceedings under this Act and shall exercise the same without regard to whether the party aggrieved shall have exhausted any administrative or other remedies that may be provided for by law.

(f) ABROGATION OF STATE IMMUNITY.—A State shall not be immune under the Eleventh Amendment to the Constitution of the United States from an action in Federal or State court of competent jurisdiction for a violation of this Act. In any action against a State for a violation of the requirements of this Act, remedies (including remedies both at law and in equity) are available for such a violation to the same extent as such remedies are available for such a violation in an action against any public or private entity other than a State.

SEC. 9. SEVERABILITY.

If any provision of this Act, or the application of such provision to any person, entity, government, or circumstance, is held to be unconstitutional, the remainder of this Act, or the application of such provision to all other persons, entities, governments, or circumstances, shall not be affected thereby.