League of Women Voters of Nashville
Position Paper on Access to Comprehensive Reproductive Services August 23, 2022

Since 1993, the League of Women Voters has actively lobbied in support of health policy solutions to contain costs and ensure quality, affordable health care for all, including comprehensive reproductive health services.[1] The League supports the right of all citizens to make their own reproductive choices, and believes that reproductive choice is not only a critical issue affecting the rights of women and all who may become pregnant, but one of racial and economic justice. [2] Overturning reproductive rights will disproportionately harm Black, Brown, and low-income people who are most impacted by systemic inequalities.[3]

On June 24, 2022, the U.S. Supreme Court voted to overturn *Roe v. Wade,* a landmark decision in place for nearly 50 years that balanced the reproductive rights of women with the right of a viable fetus to be born. The Court's decision in *Dobbs v. Jackson Women's Health Organization* disregarded what most constitutional scholars had considered settled law, and ruled that reproductive choices in early stages of pregnancy no longer belong to women living in the U.S. but are now the purview of state legislatures.

The LWV of Nashville (LWVN) stands with the national League in calling for the U.S. Congress to enact legislation to restore the reproductive rights previously guaranteed by *Roe v. Wade* as soon as possible. However, we are gravely concerned that this will not happen in time to avert serious consequences for thousands of Tennessee women and their families. Due to state legislation passed between 2019 and 2021 and triggered by *Dobbs*, as of August 25, 2022 all abortions performed in Tennessee—even those considered medically necessary or sought in cases of child abuse, rape or incest, or severe fetal abnormality—will be considered criminal acts. Our state law will no longer recognize the mental stability of pregnant women as a valid health concern. Medical providers of obstetrical, gynecological and emergency medicine who intervene in a pregnancy at any point following conception can be subject to felony prosecution unless they can prove that taking no action would have resulted in the death or irreversible impairment of a bodily function of the mother.

The LWVN calls on Governor Bill Lee's administration and the General Assembly to stay or repeal the state abortion laws that have been triggered by *Dobbs*. This ill-conceived legislation will unnecessarily deter or delay needed healthcare and have devastating consequences for thousands of women, children, and families across our state. Tennessee currently ranks 46th lowest among the 50 states in quality, cost, and access to women's health care,[3] 11th worst in maternal and fetal mortality rates,[4] and 8th worst in childhood poverty.[5] Black women in our state are 2.5 times more likely to die from pregnancy-related causes than White women, and pregnant persons with disabling health conditions face the highest mortality disparities.[6,7] Women living in rural communities often have no or limited access to obstetrical care.[8] Tens of thousands of Tennesseans of reproductive age who are living below the poverty level are denied access to preconception and contraceptive healthcare due to our state's refusal to expand Medicaid.

Policy makers should focus on enabling every pregnancy in our state to be intended and on making it possible for every family to raise children safely, healthfully, and not in poverty. This includes not only expanding access to health care but also guaranteeing affordable child care and housing, a living wage, safe schools, and supportive social environments for families.

Until a national right to reproductive choice is codified in law by Congress, the LWVN will work to repeal Tennessee's total abortion ban and oppose any abortion law which criminalizes medical interventions or denies exceptions for protecting the life, bodily function, and mental health of pregnant persons, or denies exceptions in cases of child sexual abuse, rape, incest or severe fetal abnormalities. The Board of the LWVN urges members to question all candidates running for office this fall regarding their positions on reproductive rights of women and the extreme restrictions of Tennessee's abortion law, and to hold them accountable for past decisions.

The following 3 sections are those that readers can link to from the "Read more here" links above.

Legal Background and Implications

Tennessee Abortions Rights Prior to *Dobbs*

In 2019, the most recent year for which statistics are available, there were about 9,700 induced terminations of pregnancy in Tennessee. Surgical abortions accounted for 49% and medication abortions for the remaining 51%. Abortions were allowed up to 20 weeks of pregnancy, although 89% were in the first trimester (before 12 weeks gestation). Approximately half of those having an abortion (surgical or medication) were Black. Nine percent (9%) were 19 years of age or younger, 60% in their 20's, and 28% in their 30's. Nearly 67% had never had a previous abortion and 14% were married.[9]

Prior to *Dobbs*, Tennessee law mandated a 48-hour waiting period after consulting an abortion provider, in-person counseling, and an ultrasound before termination could be completed. Tennessee also required the physical presence of a physician when providing a medication abortion. Medicaid (TennCare) could cover abortions in cases of rape, incest, or life endangerment for low-income women. There were six facilities providing abortions in Tennessee.

The *Dobbs* SCOTUS Decision

On June 24, 2022, in the *Dobbs v. Jackson Women's Health Organization* case,[10] the U.S. Supreme Court dismantled its 1973 ruling in *Roe v. Wade* which had established that women have a constitutional right to seek abortion care before the point of viability of a fetus. The *Dobbs v. Jackson* ruling leaves the regulation of reproductive rights to the states. The new ruling says: "The Constitution does not confer a right to abortion; *Roe* and *Casey* are overruled; and the authority to regulate abortion is returned to the people and their elected representatives." The current Court's majority reasoning in the 6-3 decision includes the following: "*Roe* held that the abortion right is part of a right to privacy that springs from the First, Fourth, Fifth, Ninth, and Fourteenth Amendments...The Court finds that the right to abortion is not deeply rooted in the Nation's history and tradition...Guided by the history and tradition that map the essential components of the Nation's concept of ordered liberty, the Court finds the Fourteenth Amendment clearly does not protect the right to an abortion...Attempts to justify abortion through appeals to a broader right to autonomy and to define one's 'concept of existence' prove too much."

Current Tennessee Abortion Ban

In 2020, the Tennessee legislature passed a fetal cardiac activity law which bans abortions past 8 weeks gestational age or at any point after 6 weeks gestational age if cardiac activity can be detected. Its implementation had been blocked until the *Dobbs* ruling but became state law per the 6th U.S. Circuit Court of Appeals in late June. This 2020 "heart-beat bill" (TCA 399-15-1207)[11] makes it a felony for a medical provider to terminate any pregnancy but offers an "affirmative defense" (as described below) in cases of preserving the life and bodily function of a pregnant woman. Pregnancy termination at any point is criminalized if the termination is sought for reasons of gender, race or presence of the genetic chromosomal abnormality that results in Downs Syndrome.

However, an even more restrictive 2019 law, the "Tennessee Human Life Protection Act" (T.C.A. 39-15-213)[12] will supersede the "heart-beat bill" as of August 25. Enacted to be triggered 30 days following the date on which *Roe v. Wade* was overruled, it totally bans abortion *from the moment of fertilization*, except "to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function." It specifies that a pregnant person's mental health does *not* qualify as a reason to terminate a pregnancy. There are also *no* exceptions in this trigger law for rape or incest, even for victims of child sexual abuse, nor are there any exceptions for fatal fetal abnormalities.

The “Human Life Protection Act” also criminalizes providers who terminate any pregnancy and as noted above, includes none of the exceptions that other state trigger abortion bans allow. Tennessee law now merely recognizes an "affirmative defense" for medical providers who must prove that termination of a pregnancy was warranted “to prevent the death of the pregnant woman or irreversible impairment of a bodily function.” The law could lead to criminal felony charges for anyone involved in abortion care. Performing an abortion could subject providers to a minimum of 3 and up to 15 years in prison if convicted. The fear of legal liability will force medical providers to delay lifesaving treatments, even in the absence of actual prosecution.

The Human Life Protection Act, Tennessee’s pending “trigger law,” is significant in the following respects:

1. It criminalizes all abortions whether achieved through a surgical procedure or medication with no exceptions.
2. It defines an “unborn child” as existing from the moment of fertilization.
3. It defines “pregnancy” as the condition of a women from the moment of fertilization.

Post-Roe/Pre-Dobbs abortion laws uniformly contained exceptions to the definition of abortion for rape, incest and the life and health of the mother. By carving out these exceptions to the definition of “abortion,” a criminal abortion would not be considered to have occurred if any of the exceptions applied. The burden of proving that an abortion was a criminal act Post-*Roe* and Pre-*Dobbs* was on the State.

Post-*Dobbs,* under the Tennessee trigger law, the burden of proving that a needed medical procedure is *not* an abortion has been shifted to accused medical providers. To be clear, medical providers acting on their training and Hippocratic Oaths to protect their pregnant patients’ health can now be charged with a felony until they can prove they are innocent by mounting an effective “affirmative defense.”

An affirmative defense is a concept in criminal law which allows a person who has committed a criminal offense to escape conviction if he/she can prove facts which constitute the affirmative defense. For example, in a murder prosecution, a defendant can raise the affirmative defense of insanity. To assert the defense of insanity the defendant must admit that he or she committed the offense by unlawfully killing another. With that admission, the defendant can assert that he or she is not responsible for the act because of mental illness. The burden of proving mental illness is on the defendant.

According to the trigger law, the affirmative defense applies only to abortions performed by a physician. The affirmative defense has three components, all of which must be proven by a preponderance of the evidence:

- First, in the good faith medical judgment of the physician, the abortion was necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman. (The phrases “death of the pregnant woman” and “serious risk of substantial and irreversible impairment of a major bodily function” are not defined and will have to be developed by case law).
- Second, the physician acted in such a way to provide the best opportunity for the unborn child to survive, unless in the physician’s good faith medical judgment, termination of the pregnancy in that manner would pose a greater risk of the death of the pregnant woman or substantial and irreversible impairment of a major bodily function. (Again, the phrases “greater risk of the death of the pregnant woman” and “irreversible impairment of a major bodily function” are not clearly defined and will have to be developed by case law).
- Third, in either case, the action of the physician cannot be based on a claim or diagnosis that the woman will engage in conduct that would result in her death or substantial and irreversible impairment of a major bodily function or for any reason relating to her mental health. In other words, the mental health of the pregnant woman or her threatened suicide is not justification for an abortion.

Each of these elements would have to be proven by a preponderance of the evidence which means that the evidence is more likely than not true or, put in another way, the evidence is at least 50.1% in favor of supporting the affirmative defense. The state would counter the proof offered in support of the affirmative defense through cross examination and by offering its own expert opinion disputing the assertion of an affirmative defense by a physician.

The LWVN questions the constitutionality of Tennessee's "Trigger Law" which assumes that medical providers are guilty until they can prove their innocence. This law also directly conflicts with a federal requirement to provide medical care when a pregnant person's life is at stake. A similar Idaho law that was challenged by the U.S. Department of Justice has recently been allowed to stand for now by a lower court, but is expected to be appealed by the Department of Justice.

Reproductive Health Impacts

As pointed out in the section on legal background and implications of the *Dobbs* decision, when the 2019 Human Rights Protection Act enabled by the overturning of *Roe v. Wade* becomes effective August 25, 2022, health care providers treating pregnant persons will be put in the impossible situation of facing a Class C felony conviction for intervening to protect the health of their patients. Health care providers should be able to make their medical decisions based solely on the needs and risks facing their patients and not be forced to factor in the risks of facing a prosecuting attorney and the costs of a criminal trial.

Abortion bans imposed by a number of states will place women experiencing miscarriages, ectopic pregnancies, co-occurring cancer, and other medical conditions that prevent them from carrying pregnancy to term at higher risk of maternal death and morbidity. Health policy researchers predict that banning abortion in the U.S. would lead to a 21% increase in the number of pregnancy-related deaths overall and a 33% increase among Blacks, simply because staying pregnant is more dangerous than having an abortion.[13] Criminalizing abortion is expected to lead to increased deaths due to unsafe abortions or attempted abortions and suicides.[14]
It is difficult to list all circumstances for which an abortion may be medically necessary as each case will be different. However, several clear situations are presented as examples to help understand the dire unintended consequences of extreme abortion bans:

- Conditions *threatening the life of a fetus*, such as Potter's Syndrome (absence of kidneys in the fetus), trisomy 13 and trisomy 19 are incompatible with a viable fetus. Anencephaly, an undeveloped brain and skull, is incompatible with life beyond a few days after birth.
- A pregnancy with *premature rupture of the membranes* (amniotic sac) at 16-18 weeks has only a 10% chance of progressing and is usually fatal to the fetus. The lungs of the fetus do not develop, and the fetus dies. The most likely result of premature rupture of the membranes is that the pregnant woman becomes septic with significant risk of death notwithstanding antibiotics. There is a narrow unpredictable margin when the pregnant woman who appears well then becomes severely ill and dies in spite of antibiotics.
- An *ectopic pregnancy* which occurs in up to 2% of all pregnancies,[15] may have a heartbeat, but the fetus is nonviable in any situation. It cannot be transplanted to a uterus. The pregnant woman is at serious risk of rupture and bleeding if ectopic pregnancies are not treated promptly. Criminalization of procedures needed to protect women's health could delay legitimate care needed by women who experience ectopic pregnancies
- *Spontaneous miscarriages* occur in 12-15% of recognized pregnancies, and in certain groups of women the risk is higher.[16] Miscarriages often require a surgical intervention (dilation and curettage or D & C) to remove all placental and fetal tissue to avoid serious infections. We have grave concerns that women experiencing spontaneous miscarriages will not be able to get appropriate medication or surgical

treatment in an environment where physicians responding to a tragic but natural fetal death will be considered guilty of performing an abortion procedure.

- Another serious situation arises when pregnant women in the first or second trimester are diagnosed with breast *cancer*. Breast cancer tends to be more aggressive in younger women of child-bearing age, and potent chemotherapy is often needed but cannot be given to pregnant women. Under these circumstances, a pregnant woman would need an abortion to get appropriate breast cancer therapy.

Even people who are not pregnant can be negatively affected by this law. For example:

- Autoimmune diseases are frequently treated with methotrexate, an extraordinarily effective anti-inflammatory medication taken by nearly 60% of all rheumatoid arthritis patients. This medication can make the difference between living a normal life and being bed-bound due to chronic pain. However, it can cause birth defects (in 10% of pregnancies) and miscarriages (in 40% of pregnancies). While rheumatologists would not prescribe to patients planning pregnancy, in response to criminalization of abortions, some pharmacies have stopped dispensing this medication altogether. This jeopardizes the medical treatment of patients who have no intention of becoming pregnant and who have had good control of their condition with this medication.[17]

- Isotretinoin, a commonly prescribed dermatological medication for severely scarring acne, has a 20%-35% risk of causing serious malformations in a fetus. Females of childbearing age taking isotretinoin are counseled to use regular birth control and are required to take monthly pregnancy tests. Since no form of birth control is 100% effective except complete abstinence, pregnancies do occur and termination is recommended. If dermatologists stop prescribing isotretinoin to patients of childbearing age, it takes away their autonomy and may leave them with lifelong scars. Other acne treatments are not as effective, have side-effects, and may not be covered by insurance[18].

The LWVN believes the mental health of a pregnant person must be factored into medical decisions about risk of death or disability. According to the Tennessee Department of Health's report on Maternal Mortality in Tennessee 2017-2020, 27% of pregnancy-related deaths and an additional 23% of maternal deaths in the first year postpartum are caused by mental illness.[7]

Tennessee abortion law does not make exceptions for fetal abnormalities that are likely to result in stillbirth or death within hours or days of delivery. This is an extremely traumatic event not only for the one who gives birth, but also for other members of their family. While genetic diagnostic techniques are continually improving, most current methods do not detect chromosomal abnormalities until between 8 and 18 weeks of gestation. Exceptions for non-viable pregnancies should be allowed whenever a serious abnormality is confirmed and should not be subject to arbitrary timeframes.

Exceptions should also be allowed for rape, incest and sexual abuse of a child resulting in pregnancy. The nation was horrified by news that a 10-year-old child impregnated by a rapist in Ohio was denied the option to terminate that pregnancy, just days after the overturning of *Roe v. Wade* triggered restrictive abortion restrictions in that state. The same restriction will apply in Tennessee starting August 25 and could tragically affect children under age 15 who are impregnated in our state. In 2018, 87 girls ages 10-14 were impregnated in Tennessee (39 White, 43 Black).[19] Pregnancies resulting from rape and incest at any age should also be exempted from arbitrary time frames as shame and trauma may understandably lead to delays in reporting these cases.

The LWVN believes that as long as Tennessee abortion law prevails, our state needs, at a minimum, the following:

- The provision of medically necessary pregnancy terminations must be decriminalized.

- The medical necessity of intervention in a pregnancy should be determined by a pregnant person and their medical provider, not the courts.
- The mental health of the pregnant person must be considered in assessing the risk of death and permanent damage to a person's functioning.
- Exceptions for rape, incest, child sexual abuse, and severe fetal abnormalities must be reinstated.
- TennCare and private health insurance should continue to cover pregnancy terminations to protect the life and health of pregnant women and in cases of rape and incest.

Supports for Families

Investments in comprehensive reproductive health services [defined in box below], coupled with improved economic conditions and increased access to health insurance have been found to contribute more to decreases in abortion rates than restrictive abortion laws.[20, 21]

Support for Expanded Access to Comprehensive Health Services

Income eligibility for pregnant women is 195% of the federal poverty level. Over half of all births in our state are now covered by TennCare. The LWVN welcomes the extension of maternal health coverage to a full year post-partum under our TennCare III program and is hopeful that TennCare support for doula services and community health worker support to new mothers will be approved quickly and generously. Expansion of the duration of coverage[22] and inclusion of support services are demonstrated to lower maternal death rates, improve pregnancy outcomes and promote child development.[23]

Preconception health care is also critical. According to Tennessee Department of Health's Maternal Mortality Report to the legislature this year, 46% of maternal deaths between 2017-2020 were related to conditions that could have been prevented or managed by preconception health care—cardiovascular disease, obesity, substance use disorders and mental health conditions.[7] However, many low-income Tennesseans are missing out on comprehensive health care that would improve the likelihood of healthy pregnancies. Currently in Tennessee, low-income men are only eligible for TennCare if they are disabled or caretakers of minor children and live in a household earning below 100% of the federal poverty level. The same is true for low-income women unless and until a pregnancy is confirmed. While our state has a relatively robust primary care safety net program for uninsured and underinsured individuals, many communities still lack access to specialty care, mental and behavioral health services, and the full range of reproductive health services including those provided by county and regional health departments, listed below:

- Check-ups for men and women
- Birth control information and supplies
- Emergency contraception
- Pregnancy testing and counseling
- Basic infertility services
- Reproductive life planning
- Preconception counseling
- Screening for sexually transmitted infections HIV
- Referral to other health and social services

Access to the full range of contraception must continue to be guaranteed in our state through TennCare and private insurance. Affordable Care Act Plans on the federal Healthcare Marketplace offer contraceptive

coverage. Any teen or adult, no matter their insurance status, race, sex, sexual orientation, gender identity, income, or residency status can currently go to a County Health Department family planning clinic or Federally Qualified Community or Rural Health Center for contraceptive care. The LWVN will work to ensure these services continue to be adequately funded, along with extended hours for working people and students, transportation services to those who need them, and the full range of contraceptive options, including emergency contraception (pregnancy testing and Plan B) and long-acting reversible contraception (LARCs) such as IUDs and implants. Non-profit organizations, which provides LARCs, contraceptive education and health care navigation services, also need to be supported through public and private partnerships.

Health Education

All methods of contraception work by preventing pregnancy, not terminating it. In the aftermath of the *Dobbs* decision, it is more important than ever that all Tennesseans of child-bearing age have access to accurate information about contraception.[24] Tennessee's 2020 Family Life Education law currently requires "abstinence only" reproductive education in public schools. While it can't be disputed that abstinence is an effective means of birth control, Tenn. Code Ann. § 49-6-1304 states that a family life curriculum shall "emphatically promote only sexual risk avoidance through abstinence, regardless of a student's current or prior sexual experience." There are other requirements and restrictions within the law such as a focus on sexual activity only in the context of marriage. Health educators should be permitted to discuss comprehensive sex education and family planning with teens before they become pregnant, which they are prevented from discussing by current law.

Health researchers report that there is no demonstrated effectiveness of abstinence only curricula, also known as Sexual Risk Avoidance curricula. To date, these programs have not resulted in less risky sexual behavior or delays in sexual intercourse; what's more, they withhold health information needed to make informed decisions about pregnancy and STI prevention. Many of these programs also foster gender stereotyping, and marginalize LGBTQ youth.[25]

The CDC Division of Adolescent and School Health has established an evidence-based approach referred to as "quality sexual health education" that is a systematic, effective way schools can provide adolescents the essential knowledge and critical skills needed to decrease sexual risk behaviors. Youth who participate in these programs are more likely to delay initiation of sexual intercourse, have fewer sex partners, have fewer experiences of unprotected sex, increase their use of protection (specifically condoms), and improve their academic performance.[26]

The Youth Risk Behavior Surveillance System (YRBSS)[27] is a biennial national survey developed by the Centers for Disease Control and administered by the Tennessee Department of Education. The survey monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults, including sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection. However, there are no current statewide data about sexual behaviors among Tennessee youth because our state has excluded sexual behavior questions on the YRBSS survey since 2017. Without these data, there is no way for parents, public health departments and school systems to evaluate the effectiveness of reproductive health and education programs, trends in risk behaviors, or how best to target prevention programs.

The LWVN will advocate for the following initiatives:

- Return choice of family life curriculum to local school boards.
- Make Quality Sexual Health Education as described by the Centers for Disease Control Division of Adolescent Health (CDC DASH) an optional curriculum framework.

- Develop certification programs for teachers, school nurses, and other school staff who teach health. This could be a collaborative effort among universities and departments of health and education.
- Ensure the TN Department of Education's health education and Lifetime Wellness standards are met in all grades. This will provide a foundation for lifelong health. TDOE has completed a health education crosswalk with other courses to help schools with the issue of time needed to teach all the courses required for grade progression and graduation.
- Improve understanding and trends of health-related risks among TN youth by resuming the inclusion of sexual health questions on the YRBSS.

Support of Programs that Improve Social Determinants of Health

As noted above, half of all births in Tennessee are currently covered by Medicaid, and 1 in 5 infants and children live below the federal poverty level. These bleak realities will persist and possibly intensify post *Dobbs* unless our state invests more wisely n programs that provide social and economic supports to women and their families.[28]

According to a study conducted by the Institute for Women's Policy Research, children born to women with abortion access had lower rates of poverty, were more likely to graduate college, and were less likely to receive public assistance as adults. Conversely, the financial consequences of abortion denial can be severe. Individuals denied abortions who eventually gave birth were four times more likely to have household incomes below the federal poverty level and were more likely to report being unable to afford basic necessities.[29]

Rearing a child anywhere can be complex and depends on many factors, but adequate financial support is certainly one of them. According to the Brookings Institute, it now costs $310,605 to raise a child through highschool graduation in the United States.[30] Tennessee does not fare well in addressing socioeconomic factors that can determine health outcomes. Tennessee is among states directly providing the lowest amounts of financial assistance to needy families. For every 100 families in Tennessee with children living in poverty, only 11-20 families receive Temporary Assistance for Needy Families (TANF) benefits.[31]

Other determinants of health include access to nutritious food, safe and affordable housing, healthy working conditions, a living wage, reliable transportation, education, health care, and supportive social relationships. Public policy shapes the social environment in which families struggle or thrive impacting health, productivity, and longevity.

Evidence-based social policies and programs that would minimize health disparities and build healthier families across the state include the following:

- Medicaid expansion to cover an estimated 330,000 uninsured people of Tennessee (2021) who would be eligible for TennCare
- Increased access to TANF/ Families First program benefits, including Teen Child Care Assistance for young mothers
- Expansion and extension of supplemental food assistance and school nutrition programs
- Investment in equitable access to health care, including support of rural hospitals and recruitment of primary care, specialty care, well women care, and obstetric care to underserved areas
- State support of affordable housing initiatives to increase housing stock for low-income families
- Enacting a state minimum wage increase from $7.25/hour to a living wage of $17.00/hour
- Improved methods of collecting child support so hiring an attorney is not required to enforce court-ordered child support; and state subsidies to bring single-parent families above the poverty level
- Expanded access to early childhood and PreK programs, including transportation access
- Enacting family leave policies that include provisions for parents to care for sick dependents.

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