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(Original Signature of Member)

118TH CONGRESS
1ST SESSION

H. R. _____

To expand access to abortion care.

IN THE HOUSE OF REPRESENTATIVES

Ms. PRESSLEY introduced the following bill; which was referred to the Committee on _____

A BILL

To expand access to abortion care.

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 ''Abortion Justice Act of 2023''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Abortion care is essential health care that should be affordable, available, and supported for everyone who needs it.

(2) On June 24, 2022 the Supreme Court overturned *Roe* v. *Wade* and 50 years of legal precedent, and *Roe* v. *Wade* was never enough. Without the ability to access abortion, the legal right did not help many people working to make ends meet, who are Black, Indigenous, Asian, Pacific Islander, Latinx, young people, LGBTQ+ people, immigrants, disabled people and gender nonconforming people.

(3) Almost one-third (29 percent) of the total United States population of women of reproductive age are currently living in States where abortion is either unavailable or severely restricted and a dozen other States are certain or likely to ban abortion in the future.

(4) Systemic racism, economic insecurity, abelism, and a dehumanizing immigration system exacerbate the already-massive barriers to abortion care.

(5) While abortion bans and other legal restrictions harm all people who are or may become pregnant, they cause even greater harm to those already subject to systemic racism and economic injustice.

(6) Pregnancy is less safe for some than others because of historic and ongoing racism and discrimination in health care settings, and Black and Indige-

nous individuals face two to three times the risk of dying from pregnancy-related causes. Individuals in States banning or severely restricting access to abortion care also have worse maternal health outcomes.

(7) Forced pregnancy is always unconscionable, and particularly so for individuals facing heightened risk of maternal mortality and morbidity, where pregnancy is less safe for some than others because of historic and ongoing racism and discrimination in health care settings.

(8) Maternal deaths in 2020 were 62 percent higher in States where abortion is heavily restricted than in States where abortion was available, and a Federal ban on abortion would increase maternal mortality by an estimated 24 percent.

(9) Congress has the authority to act pursuant to the commerce clause, the necessary and proper clause, and section 5 of the 14th Amendment.

(10) Attacks on bodily autonomy are not limited to threats on abortion care. This year alone, more than 120 bills have been introduced attacking gender-affirming care. States have attempted to outlaw many forms of birth control, and 15 States have near total abortion bans.

(11) Several State courts have found that abortion restrictions violate the right to bodily autonomy.

(12) The criminalization of abortion care forces people to travel hundreds of miles out of their community to try to get care.

(13) As in other forms of criminalization, the people targeted for pregnancy loss and self-managed abortion prosecution are disproportionately people of color, immigrants, and people experiencing economic insecurity.

(14) Throughout the more than 20 years that it has been used in the United States, medication abortion has been proven to be overwhelmingly safe and effective, and has expanded the way people choose to self manage their abortion.

(15) All Food and Drug Administration-approved drugs must be available in all States and territories.

(16) Research shows that with access to safe, effective methods and accurate information, people may safely self-manage an abortion on their own. Anyone who decides to end a pregnancy should be able to choose to self-manage an abortion at home with medical guidance and the support they want.

(17) Abortion needs to be accessible where people live and where they access health care. For young adults on college campuses, student health centers are often where they access the full range of care they need, and medication abortion must be accessible and available to young adults who get their health insurance through their State colleges and universities, and three States (Massachusetts, New York, and California) have passed laws ensuring access to medication abortion on college campuses.

(18) States have continually crafted legal restrictions to ensure that abortion care is burdensome or impossible to obtain. This strategy has led to more than 1,300 abortion restrictions enacted since *Roe* v. *Wade* was originally decided in 1973. These attacks are rooted in racism and compound the failures of the health care and economic systems to provide communities living with low incomes access to high-quality, affordable health care, and safe and sustainable communities.

(19) A lack of investment in both telehealth and reproductive health care is a significant barrier to an equitable experience of telehealth for medication abortion care. Actualizing the promise of telehealth and technology requires centering equity by invest-

ing in broadband, cultural competency, health literacy, and digital and physical infrastructure development.

(20) Bans on insurance coverage of abortion compound barriers to health care access for immigrant and migrant communities, which can also include logistical barriers like travel costs and distance to clinics, lodging needs and costs, childcare costs and availability, limited access to translation services, culturally competent care inclusive of low-literacy services, lost wages, and lack of paid time off for health care appointments can all delay or prohibit abortion care.

(21) Nearly two out of three people live within the 100-mile border zone that allows for interior Customs and Border Protection checkpoints where immigration officers have increased discretion to detain and question individuals.

(22) Immigrants of all statuses and people who are undocumented or in mixed-status families are deprived of the freedom to travel because of in-State immigration checkpoints that put them at even greater risk of criminalization, all of which contribute to a chilling effect for abortion access due to

heightened threats of family separation, detention, and deportation.

(23) In 2019, noncitizen immigrants aged 15 to 49 had three times the uninsured rate of naturalized citizens or people born in the United States (36 percent vs. 12 percent), and immigrants with low incomes fared worse, where in 2019 50 percent of noncitizen immigrants aged 15 to 49 with a family income below the Federal poverty level (earning less than $21,330 for a family of three) were uninsured.

(24) People held in immigration detention centers who are separated from their children and families face additional barriers to abortion care because of financial barriers due to the abortion coverage bans and other restrictions.

(25) On November 10, 2022, the Office of Refugee Resettlement (ORR) issued new guidance to ensure that unaccompanied immigrant minors have access to abortion while in ORR custody awaiting reunification with family in the United States. The Federal Government should implement policies regarding the detention of pregnant, postpartum, and nursing people, to ensure that no pregnant person is detained and if such detention occurs, that there is

no barrier to abortion while detained regardless of the detaining agency.

(26) More than 40 percent of youth and children under age 19 and 12 percent of young people age 19 to 25 have health insurance through government programs.

(27) Pregnant people younger than 18 face additional barriers to accessing abortion care.

(28) Young people face parental involvement laws in 22 States where abortion is still available, or the exercise of a judicial bypass which requires minors to receive court approval to access abortion care when they do not have their parents' knowledge or consent.

(29) Judicial bypass is not a meaningful alternative but instead another hurdle faced by young people. Many minors do not know judicial bypass is available or do not know how to get it, do not have access to transportation to travel to the necessary courts, or simply are denied bypass by resistant or biased judges.

(30) Abortion is one of the safest medical procedures in the country and leading public health organizations such as the American College of Obstetricians and Gynecologists, the American Medical

Association, and the American Academy of Family Physicians strongly oppose efforts to impede access to abortion care or interfere in the relationship between a person and health care provider.

(31) The ''2022 Violence and Disruption Report'' of the National Abortion Federation found an alarming escalation in incidents of obstruction, vandalism, and trespassing at abortion clinics, with abortion providers reporting an alarming rate of death threats and threats of harm, and documented 218 incidents in 2022, a 20 percent increase in death threats and threats of harm over 2021.

(32) Black, Indigenous, and other providers and patients of color face heightened levels of threats, harassment, and violence as compared to their White counterparts.

(33) In the face of multifaceted attacks on their work, abortion providers remain an essential and valued part of their communities, providing high-quality, compassionate, and necessary health care.

(34) There is a critical shortage of health care providers, including abortion care providers, and it is estimated that 28 percent of OB/GYN residency programs are based in States or territories that are currently enforcing abortion bans.

(35) Residents desiring abortion care training living in hostile States are forced to travel to States without abortion restrictions.

(36) Abortion care training residents face barriers to training including obtaining licensure and liability insurance, making it difficult for the next generation of abortion providers to provide comprehensive sexual and reproductive health care in their communities.

(37) In the face of the fear and stigma following the Dobbs decision, health care facilities have denied patients lawful emergency care because of the similarities in abortion care and miscarriage management.

(38) 91 facilities that provide abortion care have closed since the Supreme Court's decision in *Dobbs* v. *Jackson Women's Health Organization*. Of these, 62 facilities closed as a direct consequence of Dobbs and enforced or anticipated abortion bans.

(39) The ability to meaningfully access abortion gives meaning to the right to abortion.

(40) In the United States there is an existing support network, including abortion funds, providers, doulas, and many more, to help abortion

seekers access care and navigate restrictions with expertise in providing patient-centered care.

(41) Investments to improve telehealth would improve care for people with barriers to accessing in-person care, people with disabilities, and rural communities, by providing expanded autonomy and decreased barriers to access.

(42) Creating more opportunities for telehealth services should not substitute building much needed capacity for high-quality, in-person care, particularly in underserved rural, low-income, and Black, Indigenous, and people of color communities.

(43) Removing Federal restrictions to abortion training and investing in clinic infrastructure, including clinic security, will allow more people to provide and more people to access abortion in a safe and healthy environment and help to alleviate the drastic shortage in abortion providers.

(44) Critical investments in evidence-based, patient-centered research and innovation is needed to ensure abortion care continues to meet the needs of patients across the country and will help to improve access and quality of care.

SEC. 3. GRANT FOR FUNDING TO SUPPORT INDIVIDUALS WHO NEED TO ACCESS ABORTION CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall award grants to entities to increase abortion access or to support individuals who need access to abortion care.

(b) TIMING.—Not later than 180 days after the date of enactment of this Act, the Secretary shall award grants under this section.

(c) USE OF FUNDS.—A grant received under this section shall be used to increase abortion access or to support individuals who need access to abortion, which may include—

(1) providing abortion care in person or by means of telehealth;

(2) training health care professionals in the provision of abortion care;

(3) offering funding to individuals seeking abortion care for both the direct costs of the care and associated costs of travel, lodging, and childcare;

(4) conducting pharmaceutical and technological research and innovation in abortion care;

(5) employing patient navigators;

(6) providing linguistically appropriate and culturally competent legal assistance, case manage-

ment, translation and interpretation services, or care for individuals in need of such services related to accessing abortion care;

(7) providing the full spectrum of doula care and the full spectrum of doula training;

(8) providing escorts to support abortion seekers as they access care;

(9) constructing, installing, or improving facilities and other infrastructure for health care providers that provide or are seeking to provide abortion care, including by increasing physical security and upgrading digital infrastructure such as by switching to broadband internet service; and

(10) otherwise assisting abortion providers or individuals seeking abortion care.

(d) PRIORITIZATION.—In awarding grants under this section, the Secretary shall give priority to applicants proposing to use the award to support individuals who need access to abortion care in medically underserved communities.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $350,000,000 for fiscal year 2024 and each subsequent fiscal year, to remain available until expended.

SEC. 4. FACILITIES AND PROVIDERS.

(a) INCREASE THE NUMBER OF ABORTION PROVIDERS.—The Public Health Service Act is amended by striking section 245 of such Act (42 U.S.C. 238n).

(b) REQUIREMENT TO PROVIDE ABORTION CARE.—As a condition on the direct or indirect receipt of any Federal funds, a health care facility shall agree to provide patients with, or refer patients to—

(1) all medically appropriate reproductive health care, including abortion care, that is within the capability of the staff and medical equipment of the health care facility providing the care; and

(2) any routinely available ancillary services.

(c) UNIVERSITY STUDENT HEALTH CENTERS.—

(1) IN GENERAL.—As a condition on the direct or indirect receipt of any Federal funds, an institution of higher education shall agree to provide—

(A) medication abortion to students of the institution through—

(i) an on-campus student health center;

(ii) providers associated with a contracted external agency; or

(iii) telehealth services; and

(B) referrals to other abortion care providers located within a reasonable distance as

needed for other medically appropriate reproductive health care, including abortion care.

(d) DEFINITIONS.—In this section:

(1) The term ''institution of higher education'' has the meaning given to such term in subsections (a) and (b) of section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

(2) The term ''medically appropriate reproductive health care'' means reproductive health care that is—

(A) evidence-based; and

(B) appropriate for the patient.

(3) The term ''health care facility'' includes—

(A) any institution, entity, or agency that provides health care services; and

(B) any community pharmacy, hospital, doctor's office, health clinic, family planning clinic, emergent or urgent care facility, or community health center.

SEC. 5. COMPREHENSIVE COVERAGE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall issue a rule ensuring that all health programs or plans provide consumer-friendly information about abortion coverage provided by health programs or plans.

(b) REIMBURSEMENT FOR ABORTION CARE.—

(1) IN GENERAL.—Each person insured by, enrolled in, or otherwise receiving medical care from health programs or plans described in subsection (c) shall receive coverage of abortion services. Health programs or plans described in section (c) shall provide coverage of abortion services.

(2) AMOUNTS.—The Secretary of Health and Human Services shall issue a rule ensuring that reimbursement rates for such coverage are similar to like care and sufficient to cover the cost of care.

(c) DEFINITION.—The term ''health program or plan'' means a public health insurance program or private health insurance plan that provides, or pays the cost of, medical care (as such term is defined in 42 U.S.C. § 300gg-91). Such terms include but are not limited to the following, and any combination thereof:

(1) The Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) The Children's Health Insurance Program under title XXI of the Social Security Act (42 U.S.C. 1397 et seq.).

(3) The Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) A Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

(5) The Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(6) Medical care and health benefits under the TRICARE program (10 U.S.C. 1071 et seq.).

(7) Benefits for veterans under chapter 17 of title 38, United States Code, and medical care for survivors and dependents of veterans (38 U.S.C. 1781 et seq.).

(8) Benefits under the uniform health benefits program for employees of the Department of Defense assigned to a nonappropriated fund instrumentality of the Department established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 1587 note).

(9) Medical care for individuals in the care or custody of the Department of Homeland Security pursuant to any of sections 235, 236, or 241 of the Immigration and Nationality Act (8 U.S.C. 1225, 1226, 1231).

(10) Medical care for individuals in the care or custody of the Department of Health and Human Services, Office of Refugee Resettlement under section 235 of the William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008 (8 U.S.C. 1232) or section 462 of the Homeland Security Act of 2002 (6 U.S.C. 279).

(11) Medical assistance to refugees under section 412 of the Immigration and Nationality Act (8 U.S.C. 1522).

(12) Other coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary of the Treasury, recognizes for purposes of section 5000A(f)(1)(E) of the Internal Revenue Code of 1986 (26 U.S.C. 5000A(f)(1)(E)).

(13) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

(14) Medical care for individuals under the care or custody of the Department of Justice pursuant to chapter 301 of title 18 (18 U.S.C. 4001 et seq.).

(15) Medical care for Peace Corps volunteers under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(16) Other government-sponsored programs established after the date of the enactment of this Act.

(17) Plans in the federal marketplace or an individual marketplace within a State.

(18) Eligible employer-sponsored plan as defined in 26 U.S.C. 5000A(f)(2).

(19) Grandfathered health plan as defined in 42 U.S.C. 18011(e).

(20) A standard health plan established through a state basic health program as defined in 42 U.S.C. 18051.

(21) Other coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary of the Internal Revenue Services, recognizes for purposes of 26 U.S.C. § 5000A(f)(E).

(d) REPEAL.—Section 1303 of the Patient Protection and Affordable Care Act (42 U.S.C. 18023) is repealed.

(e) REMOVING BARRIERS TO COVERAGE FOR IMMIGRANT FAMILIES.—

(1) IN GENERAL.—Section 1903(v)(4) of the Social Security Act (42 U.S.C. 1396b(v)(4)) is amended—

(A) by amending subparagraph (A) to read as follows:

''(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, a State shall provide medical assistance under this title, to individuals who are lawfully residing in the United States (including individuals described in paragraph (1), battered individuals described in section 431(c) of such Act, and individuals with an approved or pending application for deferred action or other federally authorized presence), if they otherwise meet the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment).'';

(B) by amending subparagraph (B) to read as follows:

''(B) No debt shall accrue under an affidavit of support against any sponsor of an individual provided medical assistance under subparagraph (A) on the basis of provision of assistance to such individual and the cost of such

assistance shall not be considered as an unreimbursed cost.''; and

(C) in subparagraph (C)—

(i) by striking ''an election by the State under subparagraph (A)'' and inserting ''the application of subparagraph (A)'';

(ii) by inserting ''or be lawfully present'' after ''lawfully reside''; and

(iii) by inserting ''or present'' after ''lawfully residing'' each place it appears.

(2) CHIP.—Subparagraph (N) of section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended to read as follows:

''(N) Paragraph (4) of section 1903(v) (relating to lawfully present individuals).''.

(3) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (A), the amendments made by this subsection shall take effect on the date of enactment of this Act and shall apply to services furnished on or after the date that is 90 days after such date of enactment.

(B) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX, or a State

child health plan under title XXI, of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the respective State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(e) COVERAGE FOR INDIVIDUALS WITH FEDERAL AUTHORIZED PRESENCE, INCLUDING DEFERRED ACTION.—

(1) IN GENERAL.—For purposes of eligibility under any of the provisions described in paragraph (2), all individuals granted federally authorized pres-

ence in the United States shall be considered to be lawfully present in the United States.

(2) PROVISIONS DESCRIBED.—The provisions described in this paragraph are the following:

(A) EXCHANGE ELIGIBILITY.—Section 1411 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031).

(B) REDUCED COST-SHARING ELIGIBILITY.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071).

(C) PREMIUM SUBSIDY ELIGIBILITY.—Section 36B of the Internal Revenue Code of 1986 (26 U.S.C. 36B).

(D) MEDICAID AND CHIP ELIGIBILITY.—Titles XIX and XXI of the Social Security Act, including under section 1903(v) of such Act (42 U.S.C. 1396b(v)).

(3) TRANSITION THROUGH SPECIAL ENROLLMENT PERIOD.—In the case of an individual described in paragraph (1) who, before the first day of the first annual open enrollment period under subparagraph (B) of section 1311(c)(6) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)(6)) beginning after the date of enactment

of this Act, is granted federally authorized presence in the United States and who, as a result of such subsection, qualifies for a subsidy under a provision described in subparagraph (B) or (C) of paragraph (2), the Secretary of Health and Human Services shall establish a special enrollment period under subparagraph (C) of such section 1311(c)(6) during which such individual may enroll in qualified health plans through Exchanges under title I of the Patient Protection and Affordable Care Act and qualify for such a subsidy. For such an individual who has been granted federally authorized presence in the United States as of the date of enactment of this Act, such special enrollment period shall begin not later than 90 days after such date of enactment. Nothing in this paragraph shall be construed as affecting the authority of the Secretary to establish additional special enrollment periods under such subparagraph (C).

(f) REMOVING CITIZENSHIP AND IMMIGRATION BARRIERS TO ACCESS ACA CARE.——

(1) IN GENERAL.—

(A) PREMIUM TAX CREDITS.—Section 36B of the Internal Revenue Code of 1986 is amended—

(i) in subsection (c)(1)(B)—

(I) by amending the heading to read as follows: ''SPECIAL RULE FOR CERTAIN INDIVIDUALS INELIGIBLE FOR MEDICAID DUE TO STATUS''; and

(II) by amending clause (ii) to read as follows:

''(ii) the taxpayer is a noncitizen who is not eligible for the Medicaid program under title XIX of the Social Security Act by reason of the individual's immigration status,''.

(ii) by striking subsection (e).

(B) COST-SHARING REDUCTIONS.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) is amended by striking subsection (e) and redesignating subsection (f) as subsection (e).

(C) BASIC HEALTH PROGRAM ELIGIBILITY.—Section 1331(e)(1)(B) of the Patient Protection and Affordable Care Act (42 U.S.C. 18051(e)(1)(B)) is amended by striking ''lawfully present in the United States,''.

(D) RESTRICTIONS ON FEDERAL PAYMENTS.—Section 1412 of the Patient Protection and Affordable Care Act (42 U.S.C. 18082) is amended by striking subsection (d) and redesignating subsection (e) as subsection (d).

(E) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—Subsection (d) of section 5000A of the Internal Revenue Code of 1986 is amended by striking paragraph (3) and by redesignating paragraph (4) as paragraph (3).

(g) CONFORMING AMENDMENTS.—

(1) ESTABLISHMENT OF PROGRAM.—Section 1411(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(a)) is amended by striking paragraph (1) and redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

(2) QUALIFIED INDIVIDUALS.—Section 1312(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(f)) is amended—

(A) in the heading, by striking ''; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS''; and

(B) by striking paragraph (3).

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to years, plan years, and taxable years, as applicable, beginning after December 31, 2021.

(i) ACCESS TO COVERAGE.—

(1) IN GENERAL.—Nothing in this Act, including the amendments made by this Act, shall prevent lawfully present noncitizens who are ineligible for full benefits under the Medicaid program under title XIX of the Social Security Act from securing a credit for which such lawfully present noncitizens would be eligible under section 36B(c)(1)(B) of the Internal Revenue Code of 1986 and under the Medicaid provisions for lawfully present noncitizens, as in effect on the date prior to the date of enactment of this Act.

(2) DEFINITION.—For purposes of paragraph (1), the term ''full benefits'' means, with respect to an individual and State, medical assistance for all services covered under the State plan under title XIX of the Social Security Act that is not less in amount, duration, or scope, or is determined by the Secretary of Health and Human Services to be substantially equivalent to the medical assistance available for an individual described in section

1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)).

SEC. 6. RIGHTS AND PROTECTIONS.

(a) FUNDAMENTAL RIGHT.—All persons have a fundamental right to make and effectuate decisions about abortion and miscarriage. Pursuant to this right the Government may not:

(1) Deny, interfere with, or restrict the right of any person to obtain an abortion.

(2) Penalize any person for providing, assisting, supporting, or facilitating another person's abortion or miscarriage.

(3) Penalize an individual for seeking, inducing, or attempting to induce, the individual's own abortion or alleged abortion.

(b) CIVIL ACTION.—Any person aggrieved by a violation of this Act may bring a civil action for a such violation against a Federal, State, or local government in an appropriate district court of the United States.

(c) CLARIFY PRIVACY PROTECTIONS UNDER HIPAA.—The Secretary of Health and Human Services shall revise section 164.512 of title 42, Code of Federal Regulations, and any associated regulations under the HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act (42 U.S.C. 300jj–

19)) to clarify that such regulations expressly prohibit disclosures of personal health information without authorization to law enforcement officials, including immigration officials, in cases involving reproductive and sexual health, including in case of a miscarriage, abortion (whether self-managed or otherwise), or stillbirth.

(d) PROHIBITION WITH RESPECT TO IMMIGRATION ENFORCEMENT ACTIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, in order to ensure that an individuals' access to abortion services is protected, this Act shall prohibit immigration enforcement actions within 2,000 feet of any health care facility.

(2) APPLICABILITY.—The prohibition under paragraph (1) shall apply to—

(A) any officer or agent of the Department of Homeland Security, including any officer or agent of the U.S. Immigration and Customs Enforcement or the U.S. Customs and Border Protection; or

(B) any State or local employee pursuing immigration enforcement actions.

(3) HEALTH CARE FACILITY DEFINED.—The term ''health care facility'' includes—

(A) any institution, entity, or agency that provides health care services; and

(B) any community pharmacy, hospital, doctor's office, health clinic, family planning clinic, emergent or urgent care facility, or community health center.

(e) ABROGATION OF STATE IMMUNITY.—Neither a State that enforces or maintains, nor a government official who is permitted to implement or enforce any limitation or requirement that violates this Act shall be immune under the Tenth Amendment to the Constitution of the United States, the Eleventh Amendment to the Constitution of the United States, or any other source of law, from an action in a Federal or State court of competent jurisdiction challenging that limitation or requirement, unless such immunity is required by clearly established Federal law, as determined by the Supreme Court of the United States.

(f) SUPERSEDES.—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 date of enactment of this Act and is not subject to the Religious Freedom Restoration Act of 1993 (42 U.S.C. 2000bb et seq.).