GENERAL GYNECOLOGY

A statement on abortion by 100 professors of obstetrics: 40 years later

One Hundred Professors of Obstetrics and Gynecology

In this Journal in 1972, 100 leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in Roe v Wade. They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility. They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists. Forty years later, 100 professors examine the statement of their predecessors in light of medical advances and legal changes and suggest a further course of action for obstetrician gynecologists.

Key words: abortion, law, teaching hospital

Forty years ago, leaders in obstetrics and gynecology published a compelling statement that recognized the legalization of abortion in several states and anticipated the 1973 Supreme Court decision in Roe v Wade (Supplementary Data available at www.AJOG.org).[1] They projected the numbers of legal abortions that likely would be required by women in the United States and described the role of the teaching hospital in meeting that responsibility.[1] They wrote to express their concern for women's health in a new legal and medical era of reproductive control and to define the responsibilities of academic obstetrician-gynecologists.

Since then, we have advanced the fields of reproduction and family planning. Thanks to these developments, women can now prevent pregnancy with safer and more effective forms of contraception (most recently long-acting reversible methods), with simple and sensitive hormonal and sonographic methods to determine pregnancy status and duration, and with new methods of infertility treatment and prenatal testing that rely on the option of terminating intended pregnancies that are diagnosed as abnormal. To terminate pregnancies, clinicians now use misoprostol and mifepristone for "medical abortion" (which in 2009 accounted for 16.5% of terminations in the United States and can be office-based) and use sonographic guidance of intrauterine procedures along with new methods for inducing cervical dilation and uterine contraction; patients benefit from innovations in counseling and new approaches to pain control.[2-6] Studies of abortion practice and outcomes are also much more sophisticated than they were 40 years ago.[7,8]

We have had 40 years of medical progress but have witnessed political regression that the 100 professors did not anticipate. In 2011 alone, 24 states passed 92 legislative restrictions on abortion.[9] Waiting periods after consent are now law in 26 states. Alabama, Arizona, Florida, Kansas, Louisiana, North Carolina, Oklahoma, and Texas require patients to view ultrasound images and, in Arizona, Louisiana, Mississippi, and Texas, to listen to fetal heart beats.[10] Laws in 27 states force physicians to provide deceptive counseling including false statements about risks of breast cancer, infertility, and mental health. They include laws to limit second-trimester abortion under the guise of protecting the fetus from pain (Alabama, Idaho, Indiana, Kansas, Louisiana, Nebraska, and Oklahoma).[11] Laws directed specifically at medical education in Arizona, Kansas, and Texas prohibit abortion training in public institutions and another 7 states ban abortion in public hospitals, precluding training in them.[12]

What vision of the future of legalized abortion did the 100 professors have? How accurately did they estimate the need for safe, legal abortion and anticipate their colleagues' willingness and commitment to meeting it? They wrote, "In view of the impending change in abortion practices generated by new state legislation and federal court decisions, we believe it helpful to [respond] to this increasingly liberal course of events…by contributing to the solution of an imminent problem."[1] Forty years later, the change is not liberal. Its effects will threaten, not improve, women's health and already obstruct physicians' evidence-based and patient-centered practices. We review our predecessors' 1972 statement and judge how it comports with what actually occurred and with legislation that has been adopted over the 40 years since their writing and the passage of Roe v Wade.

The 100 professors were remarkably prescient in anticipating the need for 1 million legal abortions and today's abortion rate of 1 in 4 pregnancies.[13,14] They predicted that teaching hospitals with specialized outpatient facilities could meet the demand and believed that abortions were the responsibility of hospitals. But today, 90% of abortions, which include the 10% that are in the second trimester, are done away from hospitals.[15] Many hospitals enforce fetal and maternal health restrictions that

From the 100 Professors (Appendix).

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are not based in the law but are contrived and enforced by the same kind of "ethics committees" that were common before the professors' 1972 statement.[1] Some institutions offer terminations only to save a woman's life; others will perform the procedure under no circumstances at all. At the same time, many states have passed legislation to shut down the freestanding clinics that are now responsible for most abortions by enacting cumbersome and expensive building regulations that are disguised as patient safety requirements.[16] There are now 25 states that, under the guise of patient safety, restrict abortions to hospitals that have their own restrictions or to specialized facilities.

In our view, hospitals have disregarded the responsibility that our academic predecessors expected them to assume. Although most first-trimester and many second-trimester abortions can be done safely and efficiently in a clinic setting, some second-trimester abortions, particularly those that are complicated by medical conditions, should be done in a hospital with rapid access to the operating room, interventional radiology, blood bank, and other emergency interventions.[17] Hospitals and expert clinicians are essential for the education of students and training residents who care for complicated cases and for treating complications.

The 100 professors went on to say that physicians should learn uterine aspiration, which is an outpatient procedure that today accounts for 82.3% of abortions, and local anesthesia and analgesia, which includes conscious sedation, so that complications and expense of general anesthesia would be reduced.[6] Today, some hospitals confine pregnancy termination, even routine first and uncomplicated second-trimester spontaneous and induced abortions, to operating rooms and have credentialing rules that prohibit the use of conscious sedation for these patients.[18] Ignoring the 100 professors' counsel not only dramatically increases patients' recovery time and expense, but also adds significant and unnecessary staffing and clinical costs that discourage hospitals from providing abortions at all.

Regarding hospital policies and the role of "abortion committees," the 100 professors wrote "therapeutic abortion boards will have no place…in states with laws which stipulate that abortion decisions are to be made by the physician and his [her] patient."[1] The 100 professors commented on the physician's duty to counsel regarding abortion: "There are patients…who should be actively encouraged to consider abortion—for example, women who are unaware of a teratogenic threat to their pregnancies." At that time, the professors would have been thinking of rubella and did not know that advances in prenatal diagnosis would give obstetricians the opportunity and responsibility to make their patients aware of a wide range of genetic anomalies and to offer abortion if requested. The 100 professors certainly would not have envisioned the legislation recently proposed in Oklahoma to entitle physicians to withhold information in cases of known fetal deformity because a knowledgeable patient might choose termination.

Writing about doctors with conscientious objections, the 100 professors said that these physicians must be excused from performing abortion but must refer patients to colleagues who can care for them. Recent "conscience clause" legislation does not require referral for abortion, and some states (Colorado, Ohio, Wisconsin, Michigan, and Texas) specifically prohibit referral for abortion by physicians who work in institutions that receive state funding for women's health services.[19] The American College of Obstetricians and Gynecologists, which discussed the limits of objection, recommends that "Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled."[20] Despite this guidance, many physicians are now prohibited by law from referring patients to vital services. In Texas, for example, referral for abortion can result in denial of contraceptive funding.

The 100 professors predicted that space and resources for hospitals to provide abortion would result from "…the lessened number of septic abortions."[1] The Centers for Disease Control and Prevention and others subsequently documented a steep decline in hospital admissions and morbidity and mortality rates from illegal abortion promptly after Roe v Wade made abortion legal in all the states.[21]

The savings in lives and money from legalization were soon forgotten, and many hospitals now claim they cannot afford to provide abortions even if they wanted to because, among other arguments, reimbursement rates are too low (but abortion is certainly not the only service in this category), free-standing clinics provide faster and cheaper services with which hospitals cannot hope to compete (but some hospitals are able to provide cost-effective abortions), and hospital employees, notably nurses, refuse to provide abortion care (unlikely true of all or most nurses).

Some hospitals with abortion services still face legislative challenges. Even though many residency programs have integrated abortion training successfully, individual states and, recently the US Congress, have legislated restrictions on abortion training in disregard of Accreditation Council on Graduate Medical Education training mandates.[22,23] These restrictions ultimately threaten women's health by denying residents training in uterine evacuation, which further reduces access to safe abortion.

The 100 professors considered the consent process for abortion, stating that "…it has been ruled by [some] courts that an adult woman is free to make this decision by herself."[1] However, several state legislatures have interfered in the consent process by requiring that irrelevant, even untrue, information be given by the physician (eg, abortion causes breast cancer and fetal pain) and enacting burdensome waiting periods that increase risks and costs.[9,11] They further predicted "that the courts will someday decide that "any girl who is physically mature enough to conceive should, ipso facto, be granted the freedom to determine the fate of her pregnancies." Yet politicians in 37 states have restricted freedom of access of minors to abortion by implementing parental consent or notification laws,

often with clumsy, prolonged "judicial bypass" requirements that lead to dangerous delays.[24]

The professors addressed the need for postabortion contraception to decrease the need for abortion, endorsing it as "an integral part of any abortion program,"[1] but today the most effective contraceptives are still not easily accessible immediately after abortion when women most want them. Although the American College of Obstetricians and Gynecologists, Planned Parenthood, and other organizations promote postabortion use of long-acting reversible contraception, the family planning funding regulations of many states do not pay for immediate postabortion methods, and several states (eg, Indiana and Texas) and the US House of Representatives have attempted to eliminate family planning from their budgets entirely.[19]

Finally, the 100 professors recommended that "abortion should be made equally available to the rich and the poor."[1] Ironically, shortly after the 1973 Roe v Wade decision that our predecessors anticipated, the Hyde Amendment prohibited the use of federal dollars for abortion so that women in the military or who have received Medicaid have had severely limited access to abortion for nearly 40 years, unless they can pay themselves or happen to live in one of the 13 states that use their own funds for abortion.[25] Richer women, on the other hand, usually have private health insurance for abortions but there, too, the US Congress threatens women's health by insisting that the Affordable Care Act restrict even private payers from directly including abortion.

In consideration of current legislative threats to the autonomy of our patient relationships, to evidence-based medical practice, to the training of our students and residents, and ultimately to the health of our patients, we 100, including 2 of the original signers, join the 100 of 1972 in affirming our academic responsibilities to (1) teach future practitioners about all methods of contraception and about uterine evacuation throughout pregnancy, which ranges from miscarriage management to emergent evacuations and the treatment of complications in accordance with our professional mandate from Accreditation Council for Graduate Medical Education; (2) provide evidence-based information to all patients who seek family planning or pregnancy termination; (3) provide evidenced-based information to legislators who propose laws requiring inaccurate information or unindicated procedures for women seeking to terminate a pregnancy; (4) insist that the hospitals where we care for women and teach students and residents admit patients who require hospital-based pregnancy terminations, and (5) ensure the availability of all methods of contraception, particularly long-acting reversible contraception methods, to reduce the need for abortion. ■

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Abortion Care Network
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July 2014

Chairman Leahy, Senator Grassley, Senator Blumenthal and Members of the Committee,

The Abortion Care Network is a national 501 (c) (3) organization whose members are excellent independent abortion providers and pro-choice allies. We work to support our members, to promote access to quality abortion care, and to shift the stigma that surrounds abortion.

Many of our clinic members have served the women in their communities for over four decades. They have endured the most prolonged and deadly attacks on any professional group in our nation's history. Their dedication to women's health and welfare has sustained them in offering services under circumstances that few other professionals could withstand.

In the past several years anti abortion forces have found a strategy that makes state government an arm of their movement. We know that their ultimate goal is illegal abortion, which is indisputably dangerous for women's health. So it is truly galling to watch law after law passed under the guise of caring for women's health while really designed to inhibit access to safe abortion.

We know that abortion is, and always has been, a normal and necessary part of women's reproductive lives. Independent clinics serve good women of every race, faith, age, economic station, and culture. We have made early abortion one of the safest of all outpatient medical procedures. ACN clinics work with women and their families every day. We hold their hands listen to their stories.

The stories in this testimony represent just a glimpse of what women go through in order to access their constitutional right – a glimpse of what undue burden looks like for women. We hope you will recognize the importance of this issue to women's lives and will take all possible measures to reinstate fairness for women.

Most Sincerely,

Charlotte Taft
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United States Senate

Committee on the Judiciary

Hearing

"S.1696, The Women's Health Protection Act:

Removing Barriers to Constitutionally Protected Reproductive Rights"

Prepared Statement of Abortion Care Network

July 15, 2014

Washington, DC

Chairman Leahy, Senator Grassley, Senator Blumenthal and Members of the Committee,

It is not easy to be an abortion provider. Since Roe was decided more than forty years ago, we have been harassed, threatened, shot at and fire bombed. We wear bullet proof vests and drive ever changing routes to work. We walk daily through a gauntlet of yelling, jeering protestors who call us unspeakable things.

So why do we continue to do it? We do it because we care deeply about the health and well being of the women and families of our communities. We continue to show up, day after day, year after year because we are health care providers who understand that abortion is a part of the full range of reproductive health care services to which all women have a right and deserve access. We brush off the threats and intimidation because we know that abortion, as a critical component of reproductive justice, is necessary to a just and equitable society, one where all people are valued and can fully participate. We do it because we love our work. It is an honor and a privilege to care for women as they make profound and complex decisions about pregnancy for themselves and their families. We proudly raise our voices in the face of stigma that shames our patients and silences our supporters.

We submit this testimony on behalf of the Abortion Care Network, a non-profit organization of independent abortion providers and our allies. The Abortion Care Network protects access, promotes quality care and combats abortion stigma, by providing support, connection and resources to its members. Independent providers provide the majority of the abortions nationwide, and have been at the forefront of

abortion care since the 1970's. We are responsible for many of the innovations and advancements in abortion provision, and have been models of holistic and patient centered care.

Our primary goal, as abortion providers, is to provide the best possible care to the people of our communities. However, in states across the country restrictive legislation is limiting, and, in some cases eliminating, our ability to provide that care.

Requiring women to make multiple, unnecessary visits to a provider before accessing abortion care is based on the condescending notion that women haven't thought adequately about their decision. Laws that require these additional visits deliberately create serious hardships to those who must arrange for childcare, travel and time away from work. Mandated ultrasounds and discussion of a fetal heartbeat cause unnecessary anguish, and add to the potential emotional burden of an abortion. Medication abortion laws that mandate the use of non-evidence based protocols force doctors to operate outside of the bounds of best medical practice. State mandated, inaccurate information about the correlation between breast cancer and abortion, fetal pain, or risk to fertility, force them to lie to their patients. These laws insult women, disregard their moral agency as human beings, and pose real hurdles to access. Such restrictive laws are not found anywhere else in medical care.

And yet, women continue to jump the hurdles in search of the constitutionally guaranteed right to care they need and deserve. So, legislators take aim directly at clinics themselves with unnecessary and unreasonable regulations. These laws, passed under the guise of patient safety, are meant simply to make it impossible to continue to operate, to force clinics to close, and reduce access. In some states, clinics must look, feel, and operate like full-scale hospitals, even though abortion is among the safest of medical procedures. Doctors who perform abortions are forced to have admitting privileges at hospitals where they don't meet the minimum number of admittances to qualify. Transfer agreements between clinics, who will rarely transfer a patient, and hospitals within a certain distance are required. These transfer agreements are banned with public hospitals, so clinics are left with few or no options. When compliance is impossible, clinics are forced to close their doors.

Who suffers from these laws? Women do. Women who are doing their best to care for themselves, their children and their families. Women have always, since the beginning of time, found ways to control the timing and size of their families. Without the ability to do so they cannot participate fully in every aspect of society. We know, because history has proven it, that when made illegal or inaccessible, abortion does not go away, it simply is rendered unsafe. When the hurdles become too high to jump, or the distance between the few remaining open clinics too far to travel, women will take their unplanned pregnancies into their own hands.

We have a choice. We can be a society that shames and stigmatizes, a society where women die from unsafe abortion care. Or we can be one that compassionately supports, and insures women access to the highest quality care. We are currently on a steep and

slippery slope to the former. The Women's Health Protection Act will help us to become the latter.

Over the years, the providers of the Abortion Care Network have heard and witnessed many stories. We see first hand the impact restrictive laws have on real lives, how they exacerbate already challenging situations, making them unnecessarily harder and more devastating. The following scenarios are based on years of experience with patients and their loved ones. They are meant to walk you through complex experiences woman in this country face every day.

Kathy's Story

Kathy is a 29 year-old mother of three, and an elementary school teacher from a small city outside of Cleveland, Ohio. Her husband, Jim, was laid off from his construction job in 2009, and, unable to find full-time work, picks up jobs here and there when he can. When Kathy discovers she is pregnant, she and Jim talk long and hard about what to do. The family is already under financial stress and another child would make things that much more difficult. Kathy loves being a mother more than anything but already feels she doesn't have enough time and energy to give to her kids. After much discussion and more than a few tears, Kathy and Jim decide the best thing for their family is to have an abortion.

The prospect is scary to Kathy. Most of what she knows about abortion comes from the heated debates she sees on the news. The idea of the clinic and the procedure itself is frightening. She does, however, have one friend who she knows had an abortion a few years ago. She had gone to a large clinic in Cleveland, where she was treated very well and with kindness. She had opted for a medication abortion, and from what she has told Kathy about it, Kathy know this is the route she would like to take. She knows she is very early in her pregnancy, and would much prefer going through the experience at home with Jim, than a surgical procedure in the clinic.

Kathy hopes to be able to make the appointment for a Saturday, so that she won't have to take any time off work. When she calls the clinic, however, she is told that because of the state mandated 24 hour waiting period, she must come twice. Kathy's heart sinks at this news. She hates to take time off work: she needs to save her days off for when the kids get sick, and she really doesn't like leaving her classroom, even for a day.

But she goes ahead and makes the appointment for Thursday of the next week, and requests the day off work, saying one of the kids has a doctor's appointment.

That next Thursday, Kathy and Jim make the 45-minute drive to Cleveland. Arriving at the clinic they are horrified to find protestors outside, who shove pamphlets through their car windows and yelling out to them, "Don't murder your baby, your baby loves you", "Dad, don't let her kill her baby" It's all Kathy can do to drag Jim into the building and keep him from punching someone.

Once inside, Kathy works through all the components of her first day appointment. Her insurance will not cover abortion, so she must pay out of pocket. The ultrasound dates her at 6 weeks, and while in the ultrasound room she is told, per state law, that there is a

heart beat present and she has the option to view the ultrasound and the heart beat. Kathy chooses not to look, feeling it would make her sadder than she already is. She knows there is a heartbeat present; if there weren't she wouldn't need to be there. After ultrasound, Kathy has a session with a counselor, where they talk through her decision and how she's feeling. Kathy begins to feels somewhat better, still sad, but confident she is making the right choice. She informs the counselor that she would like to have a medication abortion, as her friend did. At this point Kathy learns that the law governing medication abortion in Ohio has changed since her friend's abortion. The new law allows medication abortion only through 7 weeks, and while Kathy is within the window, they will have to move quickly. She also learns that because of the state law, she cannot take the medication at home, but will have to come back three more times, once to take the first pill, again to take the second pills, and yet again to check and make sure the abortion was complete. She is also told that with this protocol, she could start cramping and bleeding in the car on the way home, she learns that the procedure is more expensive than she thought, as the State proscribed protocol requires three times the necessary dose, and the pills are expensive.

Kathy is devastated. The idea of a surgical procedure scares her, and she wanted to have her abortion at home, in private, with her husband. But she simply can't take more days off work to keep driving back to Cleveland, and the idea of the abortion starting in the car is scarier than the surgical procedure. Kathy talks through her fears with the counselor, and is relieved when she learns what a simple first trimester abortion involves– no incisions, no stitches. Kathy opts to come back Saturday for a surgical abortion. They finish the paperwork and head back home.

Saturday, Kathy drops the kids at a friends house and she and Jim head for Cleveland again. This time they think they are prepared for the protestors, but the crowd is even louder and more threatening than it was on Thursday. Escorts walk them into the building.

Kathy is relieved to find that the procedure is quick and relatively painless. Everyone is very kind and gentle. After some time sipping juice and eating crackers Jim drives her home. They are sad, but they are mostly relieved, grateful to go home to the kids they love.

Laura's Story

Laura and Tom were thrilled to be pregnant. They had both always wanted children. They had already told all their friends and family, had a baby shower, and finished painting a nursery in their Phoenix home. Laura had been referred to a doctor who practiced in a hospital near them. Their visits to the doctor were routine for the first few months, but when the he refused to give them a picture of their sonogram they were worried. They decided to consult with Laura's Uncle—an OB who lived across the state. Laura's mother went with them to the appointment. The pregnancy was at 22 weeks, and the ultrasound revealed the unimaginable—the fetus had holo anencephaly—it was completely without a brain.

They were all devastated. Laura's uncle explained that the fetus would likely not survive until birth, and would certainly die soon after. In the absence of a brain, there was no chance that the baby could feel pain. Laura was inconsolable. She and Tom couldn't imagine that their dreams were so shattered. They wanted to know why such a terrible deformity couldn't be detected until so late. When her uncle explained that it should have been evident on earlier ultrasounds, Tom was furious and ready to sue. Her uncle then explained that the state of Arizona, like nearly a dozen other states, protects a physician who withholds information about fetal abnormalities if he thinks a woman may consider abortion. They were speechless.

When Laura asked what would happen next, her uncle explained that the pregnancy could continue through a full 40 weeks. She became frantic at the thought of continuing a doomed pregnancy for more than four more months with everyone congratulating her and wanting to touch her stomach, when she would know all the time that there wasn't anything she could do to save her baby.

Then Laura's uncle explained that they had no other option in Arizona, where abortion is no longer legal after 20 weeks. He explained that Arizona, like several other states, have passed such bans, fueled by the claim that a fetus can feel pain at 20 weeks. Tom wanted to know if it was true that a fetus could feel pain at 20 weeks. The doctor explained that dozens of studies have proven that it is not true, but that the myth gets perpetuated by those who wish to ban abortions altogether.

Laura's mother wondered if they would make an exception in a case like Laura's where there was no hope for the fetus.

The doctor explained that, under the law, the circumstances don't matter.

Laura spoke again about her wish to be able to say goodbye to her daughter and let her go in peace. The doctor told them about an excellent facility in another state where they could still go to have an abortion. He explained that this doctor and his staff were very experienced in working with women whose pregnancies have gone very badly awry. He assured them that the clinic would understand that this is a big loss and would talk with them about how they could support each other.

Tom and Laura made all the travel arrangements. They were fortunate that they had the funds to travel and to afford a more expensive medical procedure, and that they were able to take time off work. The facility was warm and inviting and the staff was extremely kind. Laura and Tom were very touched by the other women in the waiting room of the clinic—each with her own unique story. The doctor explained the procedure Laura would go through and assured them that he and his staff would do everything they could to make a very painful emotional experience as safe and easy as possible. Laura's abortion went smoothly. They went home in great sorrow and anger knowing that unnecessary state laws had turned what was already a tragic situation into one that was much more traumatic, expensive and difficult than it needed to be. As they held hands on the plane ride back Tom and Laura vowed to share their story.

Maria's Story

Maria lives with her family in McAllen, Texas. She, and her husband Jose, are undocumented immigrants from Mexico. They have three children, all born in the United

States. Her husband is a daily farm laborer and Maria works as a house cleaner a couple of days a week, leaving her kids with a neighbor.
The family struggles to put food on the table, and the stress from lack of money and the fear of deportation has made her husband increasingly anxious and angry. She and the children are often afraid of him. She sometimes wonders if it would be better if they went back home to Mexico, but always dismisses the idea. The violence and lack of opportunity there are worse than what they face in Texas, and she wants something better for her children.
When Maria finds herself pregnant for the fourth time she knows immediately that she cannot have another child.
Maria comes from a deeply Catholic family. She knows that if she talks to Jose about the possibility of an abortion, he will say no. And yet she knows what she must do. She knows there is a clinic in McAllen that she can go to, one where she will be treated well, and that may even find her help to pay for the abortion.
But when Maria calls the clinic she is told that it has been forced to close due to a new Texas law that requires abortion doctors to have admitting privileges at local hospitals, a requirement this clinic was unable to meet. She is told she must travel to San Antonio or Corpus Christi.
Maria knows this is impossible. She has no car, she has little money. She cannot leave for any length of time without her husband knowing. She also knows there are immigration checkpoints on the road that she cannot pass through.
And yet Maria knows that having another child is also impossible. She feels it is wrong to bring another child into the family under their present circumstances. She will have to figure out another way to end this pregnancy. She knows from listening to other women that there are pills she can use to make her body miscarry. She knows little about the pills, the proper way to use them, or whether or not they will work, and yet she feels she has no other choice.
Maria takes all the money she has been secretly saving and buys the pills in the local market. She must trust that the pills are what the man says they are and that they are safe. She must trust the instructions. She can only hope that they will work and that she will be OK.

Maria's story is now the reality in the Rio Grand Valley of Texas. It is also quickly becoming the reality in states across the country like Alabama, Ohio, Mississippi and Louisiana. In these states and others, clinics are closing or are facing closure, due to unnecessary admitting privileges and transfer agreement laws, and unreasonable Ambulatory Surgical Center regulations.

These closures will leave huge swaths of the country without an abortion provider, with hundreds of miles between clinics. In some cases, closures will also result in lost access to other critical reproductive health care services, such as birth control and cancer screenings. This lack of services would be deemed completely unacceptable in any other area of health care. It is also a violation of women's constitutional rights.

Women facing unplanned pregnancies who know, deep in their hearts, that another child will be detrimental to their lives and their children's lives will be stuck with no good choices. Women, who know that continuing a pregnancy may cost them a relationship, their education, or their job, will be forced to make desperate decisions. If they are people of means and have resources at their disposal, they may be able to travel to get the services they need. Others, who don't know how they will come up with the money for the abortion itself, much less transportation and lodging, will not. Some will continue the pregnancy and have a child they did not want or are unprepared and ill-equipped to care for. Some will travel over the border, or to the local market, or go online to obtain pills, alleged to produce an abortion, without medical supervision. Some may visit one of the unscrupulous back alley providers that will inevitably pop up in the wake of clinic closure. Some will take more desperate, drastic measures that will land them in emergency rooms, bleeding and with sepsis. Some will die.

The ability to control one's reproduction and to have safe access to comprehensive reproductive health care, including abortion, is an essential human right that is recognized by international bodies and conventions. Reproductive rights are inextricably linked to other fundamental human rights, such as the right to a standard of health and living, the right to work, and the right to an education. We, the United States of America, are in danger of denying both access to safe reproductive care and other, related human rights. The members of the Abortion Care Network have daily, intimate knowledge of both the benefits of good access, and the harm that lack of access can do to the people of our communities and our country. The Women's Health Protection Act will ensure that access is not determined by your zip code, or your bank account, but is guaranteed by standards of justice and humanity. It is imperative that this Act becomes law.

Respectfully Submitted,

Dallas Schubert, Chair
Charlotte Taft, Executive Director
Abortion Care Network

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Supplemental Testimony Submitted for the Record

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Hearing on S. 1696, The Women's Health Protection Act
US Senate Committee on the Judiciary

July 21, 2014

Thank you, Chairman Leahy and Ranking Member Grassley for the opportunity to provide testimony in follow-up to the July 14, 2014 hearing on S. 1696, the Women's Health Protection Act. We hope ACOG's comments below will be helpful to the Committee in clarifying several inaccuracies found in the testimonies submitted by those in opposition to S. 1696. As the Nation's leading authority in women's health, our role is to ensure that policy discussions and decisions are based on the best available medical knowledge.

Fetal Pain:
Rigorous scientific reviews of the evidence on fetal pain in the Journal of the American Medical Association (JAMA), by the Royal College of Obstetricians and Gynaecologists, and in the Journal of Maternal-Fetal and Neonatal Medicine concluded, as recently as 2012, that fetal perception of pain is unlikely before the third trimester.[1][2][3] While abortion opponents present studies which support the claim of fetal pain prior to the third trimester, the literature cited to support a 20-week ban is less scientifically sound than the aforementioned scientific reviews.

Abortion and Breast Cancer:
As ACOG's Committee Opinion No. 434 *Induced Abortion and Breast Cancer Risk* concludes:

"The relationship between induced abortion and the subsequent development of breast cancer has been the subject of a substantial amount of epidemiologic study. Early studies of the relationship between prior induced abortion and breast cancer risk were methodologically flawed. More rigorous recent studies demonstrate no causal relationship between induced abortion and a subsequent increase in breast cancer risk."

"In 2003, the National Cancer Institute convened the Early Reproductive Events and Breast Cancer Workshop to evaluate the current strength of evidence of epidemiologic, clinical, and animal studies addressing the association between reproductive events and the risk of breast cancer. The workshop participants concluded that induced abortion is not associated with an increase in breast cancer risk. Studies published since 2003 continue to support this conclusion."[4]

Abortion and Mental Health:
Testimony submitted in opposition to S. 1696 asserts that women suffer from deleterious mental health effects after abortion. A thorough review by the American Psychological Association's Task Force on Mental Health and Abortion in 2008, and subsequent update in 2009, necessitates a correction and much more careful understanding. The report found that:

"Major methodological problems pervaded most of the research reviewed. The most rigorous studies indicated that within the United States, the relative risk of mental health problems among adult women who have a single, legal, first-trimester abortion of an unwanted pregnancy is no greater than the risk among women who deliver an unwanted pregnancy.

Evidence did not support the claim that observed associations between abortion and mental health problems are caused by abortion per se as opposed to other preexisting and co-occurring risk factors. Most adult women who terminate a pregnancy do not experience mental health problems. Some women do, however. It is important that women's varied experiences of abortion be recognized, validated, and understood."[5]

Abortion and Risk of Infection:

One witness claimed that as many as 1 in 5 women will experience an infection after having an abortion. It appears that this claim in part originates from a 1977 journal article, which cites other, even earlier findings that infections after midtrimester amnioinfusion range from 1.5% to 18.5%. Amnioinfusion abortions are rarely performed in the United States (US), so these data are irrelevant and intentionally misleading. More recent data actually shows that the rate of upper genital tract infection after induced abortion, regardless of method, is generally very low, less than 1% in most clinical settings in the US.[6] Another, even more recent study demonstrated a complication rate of 1.3% in 1st –trimester surgical abortions, with less than 0.05%—of major complications requiring hospital care.[7]

Another witness cited a Finnish study that found that "20% of the women in the medical abortion group and 5.6% of those in the surgical abortion group had at least one type of adverse event." What the witness however fails to disclose – and which the authors of the study themselves acknowledge – is that "many of the 'complications' are not really such, but rather concerns or adverse events that bring women back to the health care system."[8] Because the registry system, whose data was used for the study, does not differentiate between an actual adverse event and merely a follow-up initiated by the patient, these consultations are inaccurately coded as complications. Additionally, the outcome of hemorrhage was undefined. The authors did not report on blood transfusion, which is an objective measure of severe hemorrhage, again likely overstating adverse outcomes.

Abortion and Mortality:

While a witness was correct in stating that the overall mortality rate for women obtaining legally induced abortions increases exponentially by 38% for each additional week of gestation, the witness failed to state that the baseline is the mortality rate for women having an abortion at or before 8 weeks gestation. The mortality rate per 100,000 at that point is 0.1, so a 38% increase actually results in a very small real increase.[9] The mortality rate for women having abortions at or after 21 weeks is 8.9. While higher than for earlier abortions, this rate is still less than the maternal mortality rate of 12.7 per 100,000 among women who carry pregnancies to completion.[10] It is also important to note that only 1.5% of abortions occur after 20 weeks.[11] The witness uses her misrepresentation to bolster the justification for ultrasound dating. However, if anything, any statistically significant increase in mortality supports the need to eliminate unnecessary barriers which delay women seeking access to abortion care.

Abortion and Prematurity:
All major medical groups worldwide that have studied this issue concur that no *causal* relationship exists. This includes the World Health Organization, Royal College of Obstetricians and Gynaecologists, American College of Obstetricians and Gynecologists, American Public Health Association, American Academy of Pediatrics, and the March of Dimes.[12]

Abortion and Placenta Previa:
No causal link has been established, and no major medical association has concluded that a causal association exists. Some studies have suggested an association between abortion and this rare complication, while others have not. In contrast, the link between cesarean birth and abnormal placentation is well established, and a dose-response relationship exists. The more cesarean deliveries a woman has, the greater her risk of having dangerous placental abnormalities linked with hemorrhage, sometimes requiring hysterectomy as treatment.[13]

Abortion and Adolescents:
Opponents of the bill raise concerns about the disproportionate, adverse effects of abortion on teenagers. However research has shown that overall side effects and safety of aspiration abortion and Dilation & Extraction were similar between age groups. Younger women actually face a decreased risk of the following possible complications: uterine perforation, requiring major surgery, and mortality.[14] While younger women did have an increased risk for cervical laceration, this complication is not a cause of problems in later pregnancies. Women giving birth for the first time are also more likely to have cervical and vaginal tears during delivery. This is also not linked to later adverse outcomes. While opponents of the bill point out studies reporting complications of abortions, they fail to mention that teen pregnancies carried to term in fact come with more potential complications.[15][16]

Thank you again for the opportunity to provide you and the Committee with scientific facts on these important issues. We stand ready to provide you with factual information on medical issues that come before the Committee to ensure that scientific facts and medical evidence drive the consideration of this and other health care legislation. We look forward to working with you in support of S. 1969.

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Testimony Submitted for the Record

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Hearing on S. 1696, The Women's Health Protection Act
US Senate Committee on the Judiciary

July 15, 2014

Thank you, Chairman Leahy and Ranking Member Grassley, for the opportunity to submit testimony regarding the scientific and medical perspective on why so many state laws regulating the provision of abortion care in the name of women's health and safety, promote neither health nor safety, and why the American Congress of Obstetricians and Gynecologists (ACOG) strongly supports S. 1696, the Women's Health Protection Act.

ACOG represents 57,000 board-certified ob-gyns and partners in women's health. A large part of our work is the development and dissemination of clinical guidelines and quality improvement tools to help our members provide the highest quality care, including abortion care, to our patients. This testimony provides you and the Committee with several examples of restrictive state laws that do nothing to further women's health and safety, and which in fact can have the exact opposite effect. These include laws that:

1) Require health care providers to practice according to outdated, rather than the best and most current, medical guidelines;
2) Prohibit use of telemedicine advancements for abortion, technology that is especially important in underserved and rural areas;
3) Require abortion providers to maintain admitting privileges at local hospitals, a business arrangement that only serves to reduce the number of providers, not to improve patient safety; and
4) Require health care providers to perform tests and procedures on our patients that are not medically necessary.

All these types of laws put physicians in the terrible predicament of either adhering to medical ethics by providing high quality care that's in the best interest of their patients, or facing legal punishments which may include fines, loss of licensure, and even jail time.

1) Laws Mandating the Use of Outdated Clinical Protocols for Medication Abortions

There are several reasons why a woman may opt for a medical abortion over a surgical abortion:

- It is less invasive,
- It avoids anesthesia, and
- It takes place in the privacy of her home, a consideration that may be especially important now that the US Supreme Court has ruled against safe perimeters protecting women entering abortion clinics.

In 2000, the FDA approved use of mifepristone, together with misoprostol, to end early pregnancies. Barring any medical contraindications, there are several evidence-based protocols for medication combinations to induce termination, including use of mifepristone. During the initial office visit, a woman will receive counseling about her options. If a woman is certain that she wants to terminate the pregnancy, and she is early in her pregnancy, meaning no later than 63 days of gestation as determined by clinical evaluation or ultrasound, she may be a candidate for a medical abortion. Medical abortion requires no special pretreatment lab tests beyond those generally needed for assessment of any early pregnancy. A nurse at the medical facility can give

the patient an initial dose of mifepristone, and misoprostol will be taken at home to complete the abortion.[1]

Science and clinical evidence show that medical abortion works well for the majority of patients. Like all drugs, mifepristone carries some risks, but it is as safe, or safer, than many other drugs used today, including Tylenol and Viagra. Rates of infection and serious complications following a medical or surgical abortion procedure are extremely low. In the US, between 2001 and April 2011, there have been eight infection related deaths following the use of mifepristone and misoprostol. All were due to rare infections which have also been reported following childbirth, both vaginal and by c-section, and pelvic, abdominal or orthopedic surgery. According to FDA adverse report data, approximately 1.52 million women used mifepristone in the US, resulting in a fatality rate due to infection of 0.0005%, which is extremely low.[2] In fact, medical abortions can have safety advantages over surgical abortions for women who are extremely obese, have large uterine fibroids, certain uterine malformations, or a stenotic (narrow) cervix.[34] However, in an attempt to scare women and further restrict access to the medication, three states have passed laws which require physicians to prescribe an inferior regimen established 14 years ago, over newer, well-researched protocols.[5]

Since FDA approval in 2000, and as a result of continued medical research, a number of evidence-based regimens have emerged that make medical abortion safer, faster, and less expensive, and that result in fewer complications compared to the 2000 protocol. In March 2014, ACOG issued *Practice Bulletin Number 143 on the Medical Management of First-Trimester Abortion*. The conclusions are premised on recent studies that have shown the superiority of evidence-based regimens as compared to the 14 year old regimen set forth on the FDA-approved label.[678] Practice Bulletin No. 143 concluded that:

- Based on efficacy and adverse effect profile, evidence-based protocols for medical abortion are superior to the FDA-approved regimen. Vaginal, buccal, and sublingual routes of misoprostol administration increase efficacy, decrease continuing pregnancy rates, and increase the gestational age range for use as compared with the FDA-approved regimen.
- Lower doses of mifepristone (200 mg) have similar efficacy and lower costs compared to those regimens that use mifepristone at 600 mg.
- Women can safely and effectively self-administer misoprostol at home as part of a medical abortion regimen, eliminating the need for women to return to a health care facility for the administration of misoprostol as outlined on the FDA-approved label.

In addition to these conclusions, data also indicate that the overall risk of serious infection with medical abortion is very low and that buccal administration of misoprostol may result in a lower risk of serious infection compared with vaginal administration.[9] In fact, evidence-based regimens through at least 63 days of gestation are safer and more effective than the regimen described on the FDA-approved label when used up to 49 days of gestation.[10] As with any medical care, treatments that are safer and more effective are medically preferable.

The FDA does not require label updates for new protocols unless there are new safety concerns, which there aren't in this case. So, physicians' use of the most recent evidence-based protocols

for mifepristone is considered "off-label". The FDA allows "off-label" use of registered products when updated medical evidence supports such use.[11] In fact, "[u]p to 20% of all drugs are prescribed off-label and among some classes of cardiac drugs, off-label use can be as high as 46%."[12] Laws, such as Arizona's which mandates physician conformance with the out-of-date protocol on the FDA final printing labeling (FPL) instructions, are based on a complete misunderstanding of the role of the FDA in approving medications.

An FPL is an informational document meant to provide physicians with guidance about how to use a drug, as of the time of FDA approval. It is common for sound medical practice to advance beyond what is described on FDA drug labels. The FPL does not impose binding obligations on physicians or restrict the medical profession's ability to develop new uses for the approved drug. The FDA has, itself, noted that "[g]ood medical practice and the best interests of the patient *require* that physicians use legally available drugs, biologics, and devices to their best knowledge and judgement."[13]

A drug manufacturer needs only to demonstrate the safety and efficacy of a drug for a particular use in order to earn initial FDA approval for marketing the medication. Manufacturers are not required to seek FDA approval for additional uses.[14] Indeed, the FDA itself has observed that "[t]he term 'unapproved uses' is, to some extent, misleading."[15] The FDA has regulatory authority over the manufacturers of drugs and medical devices; it does not—and cannot—regulate physicians and the practice of medicine.

So, to be clear: there is no medical basis to prohibit a physician's use of the most up-to-date, evidence-based medication abortion protocol. Laws mandating protocols that are contrary to best medical practice are dangerous to our patients' health. Even laws that mandate a protocol that is valid at the time of the law's enactment are a bad idea. Medical knowledge continues to advance after a law's passage.

2) Laws Restricting Use of Telemedicine for Medical Abortion

The 15 states' laws that bar the use of telemedicine in the provision of medical abortion on the pretext of safety concerns related to medication abortion, are simply unwarranted.[16] Telemedicine is already used successfully in cardiac care and the treatment of post-traumatic stress disorder, and is a useful tool in ensuring access to reproductive care for many women. ACOG encourages the effective use of telemedicine to expand access to the full array of high quality health care services for women, especially those in traditionally underserved areas.[17]

One such telemedicine program for medical abortion in Iowa helps ensure women in rural areas access to this care. In this program, a woman has an in-person visit with a nurse who collects necessary clinical information, provides detailed counseling regarding pregnancy options including the potential risks and benefits of each, and engages with the patient in the informed consent process. An ultrasound is performed by a trained technician to document gestational age. A physician at another site reviews the patient's medical history and ultrasound images, and meets with the woman via video teleconference. If the physician and patient agree that she is eligible for a medical abortion, the physician enters a computer password remotely, which unlocks and opens a drawer in front of the patient and her nurse containing the medication. The

woman takes the first dose in the nurse's presence, and the remaining medications at home. The woman is scheduled for a follow-up visit in two weeks.

A recent study of this telemedicine program, published in ACOG's *Obstetrics and Gynecology* journal[18], found that women participating in this setting were no more likely to have a complication than women who saw a doctor in person. Laws that restrict access to this care interfere with the provider-patient relationship, chip away at women's access to care, and isolate reproductive care from other needed care.

3) Laws Requiring Hospital Admitting Privileges for Abortion Providers

Another set of harmful laws are Targeted Regulation of Abortion Providers (TRAP) laws. These laws single out abortion providers for regulations, with a goal of forcing abortion providers out of practice. A typical example is requiring abortion providers to obtain admitting privileges at local hospitals.

First, it's important to know that abortion is one of the safest surgical procedures performed in the United States. The overall risk associated with childbirth is approximately fourteen times higher than abortion.[19] Over 90% of abortions in the United States are performed in outpatient settings[20] and almost all complications that arise after an abortion can be, and are, treated on an outpatient basis. Hospitalization due to an abortion is rare. There is a less than 0.3% risk of major complications following an abortion that might need hospital care[21] and a recent study found that the risk of major complications from first trimester abortions by aspiration is even less, 0.05%.[22]

Having to obtain admitting privileges imposes a stricter requirement on abortion providers than on physicians that perform much riskier out-of-hospital procedures, including those that use general anesthesia. For example, the mortality rate associated with a colonoscopy is more than 40 times greater than that of abortion[23,24], yet gastroenterologists do not have to secure admitting privileges to local hospitals.

In the rare instance when a woman experiences a complication after an abortion and needs hospital care, emergency room physicians or, if necessary, the hospital's on-call specialist, are trained to evaluate such situations the same way they are trained to deal with complications arising from any other medical procedure. In fact, the transfer of care from the abortion provider to an emergency room physician is consistent with the developments in medical practice dividing ambulatory and hospital care in the medical field more broadly.[25] That is, throughout modern medical practice, often the same physician does not provide both outpatient and hospital-based care; rather, hospitals increasingly rely on "hospitalists" that provide care only in a hospital setting. Continuity of care is achieved through communication and collaboration between the health care providers which does not depend on all providers having hospital privileges.[26]

Hospital privileges establish a business relationship between the hospital and the physician, in part based on the number of procedures and admissions the physician is expected to bring to the hospital annually. Given the safety margin of abortion, including the very slim chance of complications, it's rare that an abortion provider may have to admit a patient. Privileges often also require the physician to live or practice in close vicinity to the hospital, further limiting

access to care for women in remote areas.

4) Laws that Mandate Medically Unnecessary Ultrasounds Prior to Abortion

Twelve states have active laws on the books requiring providers to perform ultrasounds before an abortion can be performed, and in some cases forcing the provider to show and describe to women the image, often under the pretext that these laws protect and enforce a patient's right to informed consent.[27] In reality, these laws are medically unnecessary, contrary to medical ethics, and in violation of our patients' right to informed consent.

North Carolina's Woman's Right to Know Act, for example, includes a Display of Real-Time View Requirement, requiring a physician to perform an ultrasound on a pregnant woman at least four hours (and not more than 72 hours) prior to an abortion procedure, to place the image in the woman's view, and to provide a detailed description of the image—even if the woman asks the physician not to display and describe the image, and even if the physician believes that forcing this experience on the patient would harm her. The district court, in a case brought to overturn the Act, correctly found that this requirement serves no medical purpose and should be invalidated, recognizing it as antithetical to principles of informed consent and unduly interfering with the patient-physician relationship.

Informed consent
The principles of informed consent forbid physicians from acting over the objections of competent patients, and ensure that a patient has the freedom to determine the information she does—and does not—wish to hear, particularly where the information provides no medical benefit. It is contrary to good medical practice and to the ethics of informed consent to force physicians to convey information that will harm their patients. Informed consent is rooted in the concepts of self-determination and autonomy, and is based on the principle, fundamental in medicine and jurisprudence, that patients have the right to make decisions regarding their own bodies.[28] Informed consent ensures that each patient is provided the information she needs to meaningfully consent to medical procedures.[29,30] Informed consent includes freedom from external coercion, manipulation, or infringement of bodily integrity. Informed consent has two essential elements: (1) comprehension and (2) free consent.[31] Both of these elements together constitute an important part of a patient's "self-determination." "Comprehension" requires that the physician give the patient adequate information about her diagnosis, prognosis, and alternative treatment choices, including the option of no treatment.[32,33]

Yet mandatory ultrasound laws force a physician to perform the procedure and deliver mandated information even over the patient's objection and even when the physician believes in his or her medical judgment that it is against the best interests of the patient to receive the information. These laws require that this information must be delivered when a patient is at her most vulnerable: in the midst of a medical procedure while the patient lies undressed on an examination table, with a probe on her abdomen or inserted into her vagina. Most informed consent discussions occur with the patient fully dressed sitting in the physician's office. And no other procedure in medicine requires that the physician show a patient images from her own body in order for her to comprehend her diagnosis and treatment options. For example, performing an angiogram before the placement of a stent is a medically appropriate preoperative procedure, but

there is no requirement that the patient view the screen before consenting to the operative procedure. Some patients choose to view medical images, others prefer not to. So too with abortion, there are simply no circumstances in which a patient's viewing of the fetus is medically necessary, and forcing her to do so unquestionably violates her autonomy and the physician's medical ethics. "Free consent" requires that the patient have the ability to choose among options; it is incompatible with being coerced or unwillingly pressured by forces beyond oneself.[34]

As an ethical doctrine, informed consent is a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care. A core principle of informed consent is that it is the patient that decides how much, or how little, information he or she wants to receive. It has long been recognized that patients can still provide informed consent while declining to receive certain information, so long as their declination is a result of free choice. If a patient chooses not to consider certain information, that is a decision a physician should respect. Advocates for the North Carolina law argued that women in their state have the ability to not see or hear the ultrasound image or the physician's words, that they can wear earplugs or close their eyes. This argument lays bare the absurdity of these requirements and clarifies that they are truly not passed to help women be better informed.

Therapeutic Privilege

In some cases, forcing a woman to view and hear these images may actually do her harm. Therapeutic privilege is the limited privilege of a physician to withhold information from a patient when, in the physician's best medical judgment, the information about the patient's medical condition and options will seriously harm the patient. For example, a physician may decline to show a cancer patient a positron emission tomography ("PET") scan showing the advanced developmental stage of the cancer because, in the physician's best medical judgment, the image would cause the patient unnecessary distress and anxiety.

Similarly, some patients seeking abortions may be seriously harmed by seeing an ultrasound image and hearing a description of it. Some women make the difficult decision to have an abortion after learning that they are carrying a fetus with severe abnormalities; having to listen to a physician explain the details of the fetus' deformities could be extremely upsetting. Others become pregnant as the result of rape. To subject those women to a forced narrative script describing the ultrasound after having already been physically assaulted and traumatized would be cruel and unnecessary. In these cases, the physician— not the State—is best positioned to determine what's best for his or her patient based on the particular circumstances of each case.

Not Medically Necessary

Many patients who have decided to have an abortion have already had at least one ultrasound performed. Most women undergo an ultrasound as part of their initial obstetric appointment; high risk patients or those carrying a fetus with abnormalities invariably undergo ultrasound to better assess fetal viability. State laws forcing physicians to perform another ultrasound on their patients are medically unnecessary. In no other area of medicine are physicians required to breach medical ethics by subjecting a patient to a medical procedure that the patient does not want to undergo and which is not medically appropriate or necessary. In fact, in any other area of medical practice, forcing an unnecessary medical procedure upon an unwilling patient would constitute medical malpractice.

Protect the Patient-Physician Relationship from Legislative Interference

This and other laws focused on limiting women's access to safe and legal abortions puts government between a patient and her physician. A physician's primary mission is to serve as a patient's advocate, exercising all reasonable means to ensure that the most appropriate care is provided to each individual patient based on his or her specific needs and circumstances. Serving the best interests of the patient also means respecting the right of individual patients to make their own choices about their health care. Laws that for no medical reason treat abortion providers or abortion facilities differently than others – or restrict the ability of women to access safe, legal abortion care are unacceptable public policy, leaving physicians with a terrible choice: Follow their ethical obligation to provide the best possible care for their patients using their sound medical judgment OR comply with the law by treating their patients according to the flawed judgment of their state legislatures. Physicians who choose to provide the best possible care for their patients in these cases may be faced with fines, jail time, and loss of licensure.

We urge the Senate Judiciary Committee and the US Congress to protect the patient-physician relationship from unnecessary government intrusion and pass S. 1696, the Women's Health Protection Act. Laws that require physicians to give, or withhold, specific information when counseling patients, or that mandate which tests, procedures, treatment alternatives, or medicines physicians can perform, prescribe, or administer harm our patients, are detrimental to the patient-physician relationship, and are a wholly inappropriate expansion of government's reach into the personal lives and health care of Americans.

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[13] FDA Information Sheet, "*Off-Label" and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices*, *available at* http://www.fda.gov/regulatoryinformation/guidances/ucm126486.htm (emphasis added).
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United States Senate
Committee on the Judiciary

Hearing
"S.1696, The Women's Health Protection Act:
Removing Barriers to Constitutionally Protected Reproductive Rights"

Prepared Statement of the UCSF Advancing New Standards in Reproductive Health Program
July 15, 2014
Washington, DC

Dear Chairman Leahy and Ranking Member Grassley:

Advancing New Standards in Reproductive Health—ANSIRH— is a program of the Bixby Center for Global Reproductive Health at the University of California, San Francisco, School of Medicine, Department of Obstetrics, Gynecology and Reproductive Sciences. We conduct research to ensure that reproductive health care and policy are grounded in evidence. ANSIRH's multi-disciplinary team includes clinicians, researchers and scholars in the fields of sociology, demography, psychology, epidemiology, nursing and public health. I am presenting to the Judiciary Committee on behalf of the faculty of ANSIRH our research findings on the effect of abortion restrictions on women's health and wellbeing. We have summarized our published research to date which may include restrictions not explicitly covered by the WHPA. Based on our research, we conclude that removing restrictions on abortion that are not based on evidence will improve women's health and wellbeing.

Consequences of denying women abortions based on gestational age
Denial of abortion care due to gestational limits occurs across the country as a consequence of state laws and abortion facility policy; an estimated 4,000 women are denied abortion services each year due to advanced gestational age.[1] By comparing the outcomes of women who were denied abortions because they were just beyond the gestational limit of an abortion facility and women who received the procedure, we found more common and more serious physical complications from birth compared to abortion. In addition, we find a greater frequency of domestic violence, poverty, and reliance on public assistance among women who carry an unwanted pregnancy to term compared to women who have abortions.[2]

Pre-viability bans
Bans on abortions after 20 weeks will disproportionately affect the most vulnerable women.[3] Most women (80%) having abortions after 20 weeks fall into one of the following groups: women raising children alone (47%); women with a history of substance use, heavy drinking, and/or depression (30%); women who experienced recent conflict or violence with their partner (24%); women who had trouble deciding what to do about the pregnancy followed by trouble accessing services (22%) and women under age 20 who had never given birth (12%). Our research on the potential impact of Georgia's 20 week abortion ban demonstrates that, if the ban goes into effect,

women of lower socioeconomic status and African American and Hispanic women will be disproportionately affected. Women seeking abortion after 20 weeks in Georgia are residents from states across the South. If the 20 week ban goes into effect, Florida will have the only post-22 week outpatient abortion care in the South. [4]

Post-viability bans

As later abortion care is not widely available in the U.S., bans after 24 weeks affect residents of states beyond the state in which the ban is enacted. Abortion care after 24 weeks is no longer available in Georgia as of January 2013. Women from throughout the South, as well as the Midwest and Northeast, are likely to be affected.[5]

Abortion bans that lack exceptions for women's health or life

Our research on obstetric care in Catholic hospitals, which prohibit abortions for any reason including maternal health, demonstrates that such restrictions lead to confusion around what practices are acceptable, and in some cases, substandard patient care. Women endure unnecessary tests, waiting or transfers, and health risk during miscarriage when the hospital's religious restrictions equate miscarriage management with abortion. Furthermore, some women with fatal fetal anomalies must endure the risks of pregnancy for up to five additional months even when the fetus will certainly die and termination would be safer and emotionally preferable for the woman.[6]

Admitting Privilege and Transfer Agreement Laws

Our analysis of post-abortion emergency department visits and complications among nearly 55,000 abortions covered by the California Medi-Cal program in 2009 and 2010 demonstrated that admitting privilege and transfer agreement laws would have limited impact on patient safety. Abortion is very safe and is associated with few serious complications. Among all abortions in the study, which included first and second trimester or later abortions, 0.03% (15 cases) resulted in ambulance transfers to emergency departments on the day of the abortion. Among all abortions, the total complication rate diagnosed and/or treated at all sources of care was 2.1%. Major complications, defined as hospitalizations, surgeries and transfusions, were rare at a rate of 0.23% of all abortions.[7]

Physician-only laws

Regulations that identify the health care professionals who can provide abortion care should be based on education, training and clinical competency rather than a particular licensure. Our research demonstrates that nurse practitioners (NPs), certified nurse midwives (CNMs) and physician assistants (PAs) provide aspiration abortion care with clinically equivalent complication rates to that of physician providers.[8] This study also found that abortion care is extremely safe. Among the 11,487 first-trimester clinic-based procedures examined in the study, the overall complication rate was 1.3% and the major complication rate, defined as having involved hospital admission, surgery, or a blood transfusion, was 0.05%.

Restrictions on Medical Training for Abortion Procedures

Our research on abortion training for ob-gyn residents demonstrates that the skills learned during this rotation are essential for all ob-gyns, not only those intending to provide abortions in their medical practices. This training prepares doctors to treat women suffering from miscarriage, previable premature rupture of membranes and chorioamnionitis, and situations in which continuation of the pregnancy significantly threatens the life or health of the woman. Bans on abortion training in residency programs will hamper their ability to provide essential care for women facing a variety of reproductive issues.[9]

Mandatory Ultrasound Laws

ANSIRH's research demonstrates that laws requiring women to view their ultrasounds before an abortion and would have a very limited effect on women's decision-making around abortion. Our study among 15,575 visits to a large US abortion provider demonstrated that, given the option to view the ultrasound, most women (57%) chose not to view.[10,2] When we examined whether viewing the ultrasound affected women's abortion decisions, we found that nearly all pregnancies (98.8%) were terminated: 98.4% of pregnancies among women who viewed their ultrasound

images and 99.0% of pregnancies among the patients who did not, with the difference attributable to women who were less decided about having an abortion being more likely to view.[11,3]

State-Mandated Counseling
Abortion regulations mandating state-approved counseling are based on the notion that current counseling practices fail to adequately inform women about the risks and benefits of the procedure. A study of 718 abortion patients from 30 US facilities revealed that the majority of women found counseling to be helpful. However, women who received counseling from abortion facilities in states requiring provision of specific information and/or state-approved written materials were significantly less likely to have found counseling helpful, compared with women receiving care at facilities in states without such restrictions.[12] Furthermore, the great majority of women are highly confident in their decision to terminate a pregnancy when they present at an abortion facility. Data from 5,109 abortion patients at a large US clinic demonstrated that, for 87% of the abortions sought, women had high confidence in their decision before receiving any counseling.[13]

Multiple visit requirements
Requiring women to complete an in-person informational visit in advance of an abortion does not appear necessary as most women are certain of their decision when they seek abortion care. The requirement also creates logistical challenges for women, requires them to tell more people about the abortion, adds costs for this already financially insecure population, and results in delays of more than a week between the initial visit and the abortion. [14]

Mandatory Waiting Periods
Our study of Utah's abortion waiting period suggests that requiring women wait 72 hours between an information visit and receiving an abortion actually results in delays of more than a week between the two visits. Waiting an additional week results in an extended period of nervousness about the procedure, ongoing nausea and pregnancy symptoms, and disruption of work and school responsibilities. For a very small number of women, this delay results in exceeding the gestational limit for abortion at the facility. This can put them at a gestation at which they can no longer afford the cost of the procedure and thus must continue the pregnancy.[15]

Reasons-based Abortion Bans
The reasons women seek abortion are complex and interrelated and include financial reasons, timing, partner-related reasons, and the need to focus on existing children. Almost two-thirds of women in one study reported multiple reasons for seeking an abortion.[16] Restricting access to abortion is the primary motivation for sex-selective abortion bans. Research demonstrates that sex-selective abortion bans are not associated with changes in sex ratios at birth. An analysis of sex ratios five years before and after sex-selective abortion bans enacted in Illinois and Pennsylvania were not associated with changes in sex ratios in those states.[17]

I thank you for your attention to the evidence. Based on this body of research, I don't believe that most restrictions on abortion improve women's health or wellbeing. Removing unnecessary restrictions can improve women's access to medical care.

Sincerely,

Diana Greene Foster, PhD.
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Associate Professor, Bixby Center for Global Reproductive Health
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Planned Parenthood of Southern New England

TO: Senator Patrick Leahy, Chair, US Senate Committee on the Judiciary
Senator Charles Grassley, Ranking Member

Written Testimony of Planned Parenthood of Southern New England
July 15, 2014
US Senate Committee on the Judiciary Hearing on the *Women's Health Protection Act*

Unlike states where politically-motivated restrictions have been placed on reproductive health care, Connecticut can point to positive social outcomes, because these services are seen through the lens of public health, not politics.

A strong body of law exists in CT protecting access to reproductive health care:

- Connecticut is a state where lawmakers and state public health officials, as well as advocates and health care providers have long agreed upon the importance of preserving confidential access to reproductive health care.

- Connecticut has a strong longstanding body of statute allowing confidential access to a range of sensitive health care including STD and HIV testing, mental health services, drug and alcohol abuse counseling, contraceptive and abortion access, which includes specific protections for minors who need to access these services.

Good state policy results in public health outcomes *we all can agree upon*:

- The sensitive nature of reproductive health services, combined with the unfortunate culture of silence that can surround the use of them, make it vital that individuals who need care have sure and direct pathways to providers, not additional barriers, costs, shame or judgment, or expensive, unnecessary medical procedures.
- Because services are conveniently located and funding for services is available, during the past few months medical staff at Planned Parenthood of Southern New England were able to diagnose 14 life threatening medical conditions, from ectopic pregnancy to breast and cervical cancer to choriocarcinoma.
- As a result of good state public policy surrounding reproductive health care, the number of abortions in Connecticut has decreased dramatically. Between 2008 and 2013 alone, the CT State Department of Health reported that the number of abortions obtained by women under age 20 decreased by 58% and decreased by 67% to women under age 18.

- Abortion is a safe and common medical procedure with about one in three American women experiencing an abortion by age 45. It is also among the safest medical procedures with less than 0.05% of procedures leading to complications that might involve hospital care.[1]

CT has obtained these results through sensible oversight not increased barriers to reproductive health care:

- The State of Connecticut Department of Public health both licenses and inspects all outpatient clinics offering reproductive health services.
- The State of CT does not require the unnecessary or excessive regulations regarding physical plant and layout that some states have adopted, targeting these rules specifically at centers where abortion is offered.
- Providers in Connecticut are guided by professionally accepted medical standards of care, not by politically driven laws that impact their profession and practice of medicine by requiring them to offer particular information or procedures. For instance, most abortion providers offer ultrasound as a standard practice, not because lawmakers have mandated that it be performed.

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CENTER FOR REPRODUCTIVE RIGHTS

The Honorable Patrick Leahy
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The Honorable Chuck Grassley
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July 15, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

I am writing on behalf of the Center for Reproductive Rights to express our strong support for S. 1696, the Women's Health Protection Act of 2013.

Although the Supreme Court of the United States held in *Roe v. Wade* that a woman has the constitutionally protected right to decide whether or not to terminate her pregnancy, and nearly one in three women in this country will exercise that right, a woman's ability to safely and legally end a pregnancy is being steadily eroded, such that it is now dependent on where she happens to live.

The attached testimony outlines how states are restricting access to abortion under the pretext of protecting women's health, while they are in fact jeopardizing women's health by shutting down access to essential reproductive health care.

The Women's Health Protection Act would ensure that laws and regulations that truly advance health and safety are maintained, while dangerous regulations passed under pretext that stifle access to abortion care and endanger women's lives would be prohibited. We applaud the introduction of this essential legislation and thank you for the opportunity to submit our testimony in support.

Nancy Northup
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July 11, 2014

Dear Chairman Leahy and Ranking Member Grassley:

We, the undersigned organizations, represent health care and public health professionals who care for women and their families every day. We write in support of the Women's Health Protection Act of 2013 (S. 1696).

For decades, politicians across the country have passed harmful restrictions on abortion in an attempt to roll back a woman's ability to make health care decisions for herself. In many states, the effect has been catastrophic. Abortion care has become virtually impossible to obtain for far too many women. In fact, six states - Arkansas, Mississippi, Missouri, North Dakota, South Dakota, and Wyoming - currently only have one abortion clinic.

Every woman has her own unique circumstances and must be able to make personal medical decisions, including the decision to have an abortion, without political interference. As health care providers and public health professionals, we work every day to make sure women receive the high-quality health care they need in a safe, respectful environment. Political intrusion into the patient-provider relationship is dangerous.

Abortion access has been in peril for several years. In recent years, however, politicians have increasingly sought new ways to interfere with the patient-provider relationship and undermine women's access to abortion care. State legislatures have been more active than ever in passing burdensome requirements that single out abortion providers and services and do nothing to advance women's health or safety. Politicians are not medical experts and yet politicians have written these laws with the end goal of having safe, legal abortion difficult or even impossible to access.

For example, states have approved:

- Requirements that health care providers perform tests and procedures even if they are not medically necessary;
- Measures that force health care providers to follow outdated medical guidelines rather than follow the current standard of care;
- Prohibitions on using telemedicine advancements for abortion;
- Regulations for women's health centers that are burdensome and medically unnecessary and serve only to make it harder for clinics to stay open;

- Requirements that physicians providing abortion maintain admitting privileges at local hospitals, despite the safety of abortion and the fact that admitting privileges are not necessary in the event of a complication;
- Measures that require a woman who has decided to have an abortion to make multiple unnecessary trips to the abortion provider; and
- Legislation forcing a woman to visit an anti-abortion "crisis pregnancy center."

These restrictions target abortion providers and women seeking abortion care with regulations and requirements that are not imposed on any other health care providers. Moreover, these laws and policies have been passed under the guise of protecting women, and in fact fail to improve women's health or safety because they are not based on medical and scientific evidence. These requirements greatly impede women's access to safe and legal abortion.

As groups representing health care and public health professionals across the country, we understand that abortion access is fundamental to women's health. Abortion is a safe medical procedure and complications are rare. These restrictions prevent health care providers from offering abortion care, limiting women's access to safe and comprehensive reproductive health care.

It is time to put a stop to laws that are unrelated to scientific evidence and are counter to the health care needs of patients. We need a federal law that will protect all women's access to abortion so that health care providers can deliver the best possible care. A woman's ability to obtain a safe and legal abortion should not depend on her zip code. We need the Women's Health Protection Act. We thank you for calling a hearing on this critical legislation and pledge our support in working toward its passage.

Sincerely,

American Congress of Obstetricians and Gynecologists
American Medical Student Association
American Medical Women's Association
American Nurses Association
American Public Health Association
Association of Reproductive Health Professionals
Medical Students for Choice
National Abortion Federation
National Family Planning & Reproductive Health Association
National Physicians Alliance
Physicians for Reproductive Health
Planned Parenthood Federation of America
Society for Maternal-Fetal Medicine

July 14, 2014

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Leahy and Ranking Member Grassley,

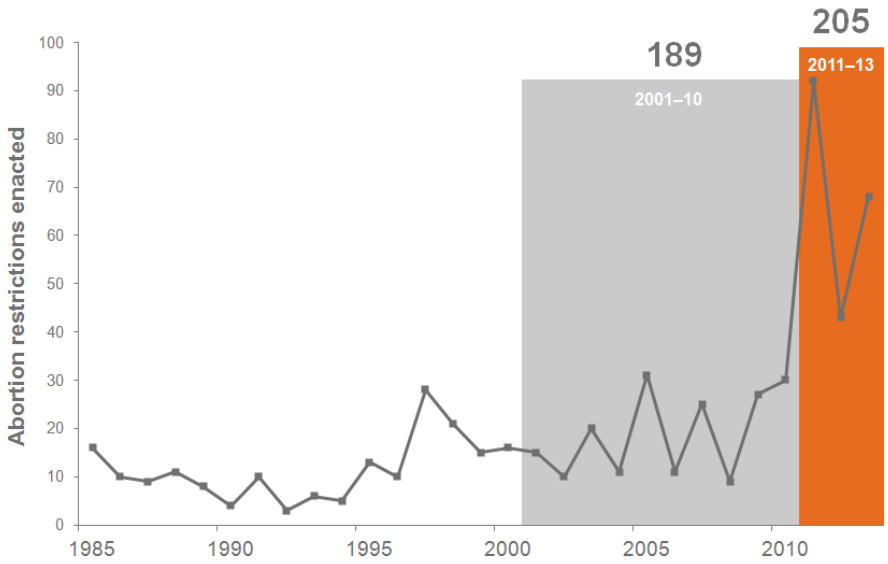
Thank you for the opportunity to submit this statement on behalf of the Guttmacher Institute in support of the Women's Health Protection Act of 2013, S. 1696, for the July 15, 2014 hearing entitled: The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights.

The Guttmacher Institute is an independent, not-for-profit organization focusing on sexual and reproductive health research, policy analysis and public education in the United States and internationally. The Institute's work is considered authoritative and is cited as much by opponents of reproductive rights as by advocates of those rights. Guttmacher monitors, analyzes and regularly updates the status of state laws regarding a range of reproductive health and rights issues, including restrictions on access to abortion care. Moreover, the Institute has collected and analyzed a great deal of information on abortion incidence and trends nationwide.

The avalanche of restrictive state abortion laws, especially since 2010, demonstrates why the time is now for a federal law such as the Women's Health Protection Act (WHPA) to address the fact that in wide swaths of the country, access to abortion care is increasingly difficult if not impossible for many women.

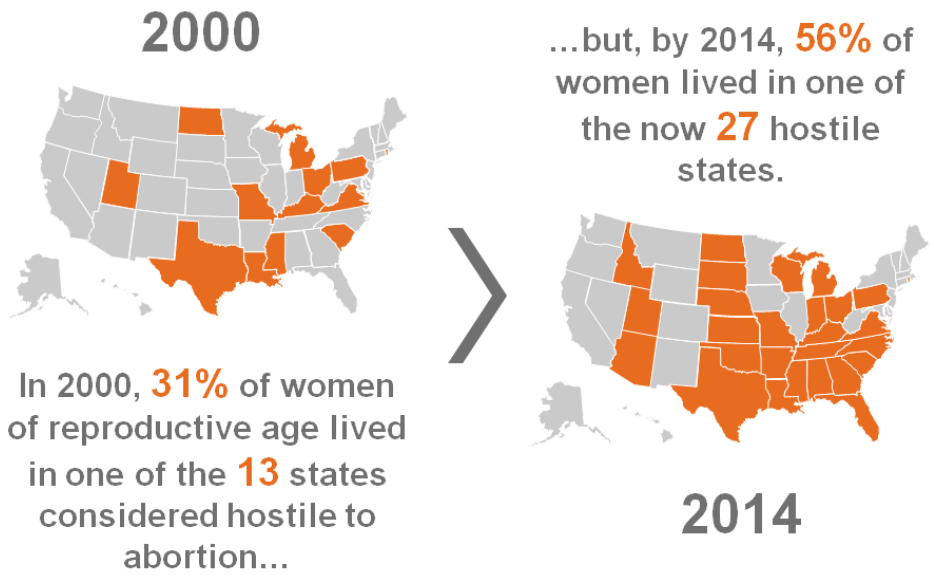
The primary purpose of the WHPA is to guard a woman's right and ability to access safe, legal abortion services and ensure that providers and health care facilities are not targeted by unwarranted restrictions. The bill would invalidate unnecessary and burdensome regulations known as targeted regulation of abortion providers (TRAP) and overturn policies on medication abortion that make it more difficult for women to access early abortion. The bill would also outlaw previability abortion bans and invalidate any laws that compel women to make multiple trips to the provider for reasons unrelated to medical necessity, be it state-dictated counseling or mandatory ultrasounds. Young women, poor women and women of color bear the brunt of the obstacles to care that these types of laws are creating and therefore have the most to gain from the bill's enactment into law.

Trends in State Laws. An unprecedented wave of state-level abortion restrictions swept the country over the past three years, as is described in the Institute's *Guttmacher Policy Review* article, *A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs*. In 2011–2013, legislatures in 30 states enacted 205 abortion restrictions—more than the total number enacted in the entire previous decade. No year from 1985 through 2010 saw more than 40 new abortion restrictions; however, each year between 2011 and 2013 topped that number.



In terms of sheer numbers, this wave of new restrictions has shifted the abortion policy landscape dramatically. To assess how and where the volume of abortion restrictions changed over time, analysts at the Guttmacher Institute identified 10 categories of major abortion restrictions and considered whether—in 2000 and 2014—states had in place at least one provision in any of these categories. A state was considered "supportive" of abortion rights if it had enacted provisions in no more than one of the restriction categories, "middle ground" if it had enacted provisions in two or three, and "hostile" if it had enacted provisions in four or more.

According to the analysis, the overall number of states hostile to abortion rights—and the proportion of U.S. women living in those states—has grown substantially since 2000, while the number of supportive and middle-ground states has shrunk:

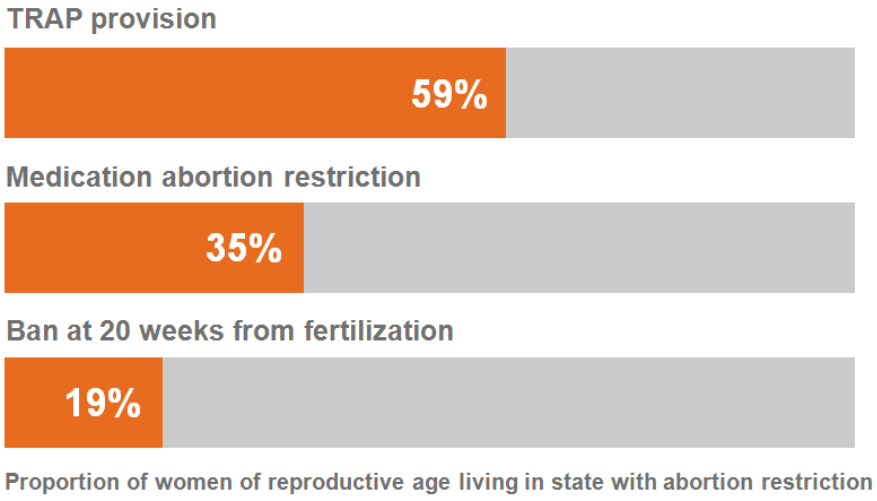


Antiabortion leaders disingenuously insist that these restrictions are necessary to protect women's health and safety. The safety of abortion, however, is well established. Rather, these restrictions burden women and potentially threaten their health. And they prevent providers from engaging in practices that are accepted as mainstream in other medical specialties. Simply put, restrictions on abortion make the procedure more costly—financially and in terms of women's health and safety.

Abortion Rate Is Declining. Antiabortion activists have been quick to jump on the recent wave of restrictions as the explanation for the reported decline in abortion in recent years. A Guttmacher study released earlier this year found that the U.S. abortion rate dropped 13% between 2008 and 2011, and had reached its lowest level since 1973. The dramatic drop during this most recent period cannot be explained by the recent rash of state restrictions, however, according to the *Guttmacher Policy Review* article *U.S. Abortion Rate Continues to Decline While Debate over Means to the End Escalates*. First, the abortion decline mostly predated the wave of new abortion restrictions. Moreover, since the drop in the abortion rate was accompanied by a steep drop in the birthrate too, it is clear that it was the drop in the overall pregnancy rate that was the underlying factor. The evidence shows that improved contraceptive use, including use of highly effective methods like the IUD and implant, was likely the main driver of the abortion decline by helping to reduce women's need for abortion care.

Women Pay the Price. Even though abortion restrictions appear not to have been a major factor in the most recent abortion decline, the analysis warns that such laws can have a severe financial and emotional impact on women even when falling short of deterring them from having an abortion. In 2014, 59% of women of reproductive age live in one of the 26 states with TRAP laws and 35% of women live in one of the 16 states that limit access to medication abortion. And research shows that the most coercive laws, those that significantly raise the economic cost for women seeking abortion care, can have a

measurable impact on abortion incidence by making abortion unattainable for the poorest and most vulnerable women.



"Abortion opponents may try to cloak their policies in prowoman rhetoric, but the simple fact remains that these laws are intended to push reproductive decision making in one direction: toward pregnancy and childbearing," as the article explains. "Viewed this way, the question is not whether coercive approaches 'work' in reducing abortion incidence. Rather, these coercive approaches are unacceptable in principle. U.S. women and couples have been increasingly successful at achieving their goal of having small families, and they increasingly are doing so without relying on abortion. Even with abortion services legal and accessible to women who need them, abortion can become more rare—for all the right reasons."

Given the demonstrated hostility toward abortion rights in so many states, it is clear that enactment of the WHPA is necessary and urgent. In blocking key aspects of the concerted nationwide antiabortion campaign that neither promotes women's health nor can reduce the need for abortion, enacting the WHPA would begin to restore respect for and protection of women's health and dignity no matter where in the United States they live.

Thank you for the opportunity to provide these comments.

Sincerely,

Susan A. Cohen

Susan A. Cohen
Acting Vice President for Public Policy
Guttmacher Institute

United States Senate

Committee on the Judiciary

Hearing

"S.1696, The Women's Health Protection Act:

Removing Barriers to Constitutionally Protected Reproductive Rights"

July 15, 2014

Washington, DC

Testimony of: Kelly Blanchard, President; Amanda Dennis, Associate; Kate Grindlay, Senior Project Manager; Daniel Grossman, Vice President for Research; and Britt Wahlin, Director of Development and Communications

Ibis Reproductive Health
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617-349-0040

Dear Chairman Leahy and Ranking Member Grassley:

We, at Ibis Reproductive Health (Ibis), offer this testimony in strong support of H.R. 3471: The Women's Health Protection Act of 2013. Ibis is a nonprofit organization with a mission to improve women's reproductive autonomy, choices, and health worldwide. Our core activity is clinical and social science research on sexual and reproductive health issues receiving inadequate attention in other research settings and where gaps in the evidence exist. One of our priority research areas is exploring and documenting the impact of laws restricting access to or the provision of abortion care.

Since abortion was legalized in the United States (US) in 1973, states have created hundreds of laws limiting whether, when, and under what circumstances a woman may obtain an abortion.[1] In recent years, abortion restrictions passed at an alarming rate; from 2011 to 2013 states enacted 205 new restrictions on abortion, more than were enacted in the entire previous decade.[2]

Summary impact of laws restricting abortion

Those who propose and pass abortion restrictions often claim that the laws are designed to protect the health and well-being of women and their children.[3-5] However, a large and growing body of peer-reviewed, high-quality research shows that restricting abortion does not benefit women or their children. Instead, restrictions on abortion can lead to a number of emotional, financial, and physical harms. Some restrictions delay or make it more difficult to access abortion care, leading to negative emotional and financial outcomes and decreased well-being as women try to navigate abortion care hurdles.[6-11] Delays also increase the risks and costs of the abortion procedure. Other restrictions block access to abortion all together, interfering with women's abilities to make their own reproductive decisions and preventing their achievement of life plans and goals. Women denied abortion care are also at increased risk of experiencing poverty, physical health impairments, and intimate partner violence.[6,9, 12-20] Below, we provide more detailed information about the negative impacts of a selection of the abortion restrictions that would be addressed by The Women's Health Protection Act of 2013. We start with restrictions that we have researched extensively and then address restrictions studied by other well-respected researchers.

Impact of restricting telemedicine

Fifteen states require that a clinician be physically present when providing medication abortion, and in one additional state, Iowa, there is pending litigation.[21] These laws restrict the use of telemedicine, which is the delivery of health care services at a distance using information and communication technology. However, there are no data to support these restrictions. On the contrary, our research evaluating the use of telemedicine for medication abortion services in Iowa found that telemedicine provision of medication abortion is safe, effective, and acceptable to women and providers.[22-23] Ninety-nine percent of telemedicine patients had a successful abortion, and adverse events, such as going to the emergency room or needing a blood transfusion, were rare, occurring among 1% of patients seen either by telemedicine or in a face-to-face visit. While satisfaction with the abortion was high among all patients (91% reported they were 'very satisfied'), telemedicine patients were more likely to report they would recommend the service to a friend compared with face-to-face patients.[22] Our research has also shown that telemedicine availability resulted in women accessing abortion services at earlier gestational ages and increased access to services for women living in remote parts of the state.[24] Telemedicine is increasingly being used across medical specialties, and more than half of US hospitals use telemedicine in some way.[25] Restrictions on telemedicine for medication abortion are not evidence based, and limit women's access to high-quality abortion care, particularly in rural areas.

Impact of requiring women to make one or more medically unnecessary visits prior to abortion

In 35 states, women seeking an abortion must undergo counseling before obtaining an abortion. Eleven of these states require that counseling be provided in person, which means that women must make two separate trips to a facility to obtain an abortion.[26] We collaborated with the Guttmacher Institute and conducted an extensive review of the peer-reviewed literature evaluating the impact of these restrictions. We reviewed 12 papers in depth and determined that having to make one or more medically unnecessary visits prior to an abortion can delay a woman's access to abortion, and increase a woman's mental and physical distress. Our review also showed that these restrictions can increase the proportion of second-trimester abortions, which increases risks and costs of the procedure.[8] New research conducted since the literature review was completed shows that requiring women to make one more medically unnecessary visits prior to an abortion can have a negative effect on their emotional well-being.[27]

Impact of requiring doctors to adhere to outmoded and less effective medication abortion regimens
Three states require that medication abortion be administered in accordance with the outdated US Food and Drug Administration labeling.[21] This forces doctors to administer early abortion medications in a way that does not reflect the best clinical evidence, denies women access to new, evidence-based regimens for care not reflected in the label, and reduces the number of providers able to offer medication abortion.[28] Although the labeling in the US does not reflect it, extensive clinical evidence and global best practice show that a reduced dose of mifepristone and home use of misoprostol is the gold standard.[29] It is common for health care providers to practice evidence-based medicine using approved medicines off-label in the US. Many women prefer medication abortion—in 2011, 36% of abortions before nine weeks' gestation were medication abortions[30]—and requiring an outmoded and less effective regimen for medication abortion singles out the procedure and ties the hands of health care providers trying to offer high-quality care, while having no medical benefit.

Impact of imposing ambulatory surgical center standards on facilities providing abortion
Currently, 26 states require that facilities providing abortion must meet the standards for ambulatory surgical centers (ASCs).[31] ASCs are outpatient facilities where patients can obtain surgical care without being in a hospital setting. Generally, ASCs provide much riskier and more invasive procedures than abortion providers. Meeting the extensive standards of an ASC can involve expensive changes to a clinic's physical infrastructure/building, such as expanding room sizes or corridors beyond what is necessary for patient care. Imposing ASC standards on facilities providing abortion care can reduce the number of providers able to stay open and offer care, limiting women's access to abortion. These standards also increase the cost of care, which can further impede access.[6]

Impact of imposing gestational age limits on abortion
Forty-two states restrict abortion beyond a certain gestational age.[32] Gestational age limits can prevent women from being able to access care and force them to continue unwanted pregnancies. They also force women needing abortions to spend time and money to travel to other states for their abortion care.[7] Not being able to access care because of gestational age limits can also reduce women's self-esteem and life satisfaction, and increase feelings of regret and anger.[7,17-19]

Compounding impacts of abortion restrictions
The overwhelming majority of states have more than one restriction on abortion in place.[33] This means that most women seeking care must navigate a number of different laws seeking to limit timely access to a legal and safe medical service. Facing numerous abortion restrictions simultaneously can delay access to care and increase the difficulty of obtaining care (if, for example, a woman has to take off work and arrange childcare to comply with multiple visit requirements). When abortion is delayed and the logistical challenges of accessing the service increase, the out-of-pocket costs of the procedure also increase. Increasing the cost of the procedure can interfere with women's personal medical decisions, undermine women's autonomy by putting care out of financial reach, delay women even further from obtaining abortion care while they search for the financial resources to pay for abortion out-of-pocket, force women and their families to endure financial hardships to afford care, and force women who cannot afford abortion care to continue unwanted pregnancies,[9-11,34] which can push women into poverty.[14]

Conclusion

An extensive body of high-quality, peer-reviewed research has documented the significant harmful effects of abortion restrictions for women and their families. Women need a federal law that will protect them from these harmful restrictions, and put their health and rights first. If enacted, The Women's Health Protection Act of 2013 will prevent legislators from limiting women's ability to get high-quality, evidence-based health care and ensure women can access constitutionally-protected services. Passing the law would enable women to implement their own private, medical decisions and allow medical providers to follow best practices and offer safe, legal, high-quality health care. We urge the committee to support this fight for the health and well-being of women and their families. Please give support to this historic piece of legislation.

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The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 18, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

I am writing in support of S. 1696, the Women's Health Protection Act.

I am an obstetrician-gynecologist practicing in Utah. I recently completed a family planning fellowship at the University of Utah in Salt Lake City and will be staying in Utah to provide much-needed health care services in under-served areas. I have made patient advocacy a professional focus in addition to publishing clinical research and providing high-quality medical care. I received my medical degree from the University of Illinois at Chicago and completed a residency in obstetrics and gynecology at Albert Einstein Medical Center in Philadelphia.

As a physician who performs abortions as part of comprehensive medical care, the Women's Health Protection Act allows doctors to practice the safest kind of medicine: evidence-based medicine. Many of the state laws that are passed are directed at abortion providers under the guise of safety. If that were true, other doctors in other specialties should have to conform to the same laws for the procedures they perform that carry the same, if not higher, risks. This is not the case. The testimony given by Dr. Chireau was inaccurate on many counts, including providing research data that is outdated and poorly done. (That is to say, research that was either not peer-reviewed or has not held up to academic scrutiny.) Below are some examples of state-level laws that are passed and how they actually harm, not help, people and their families. I practice medicine in a conservative state and know first-hand the damage that having my hands tied by the law can do to people.

1. The Mandated Use of Ultrasound

Legislators have decided that they know better than doctors when and how ultrasounds should be used in abortion care. Some laws require a woman to receive written information regarding her right to see the ultrasound, some obligate her to see the ultrasound, and some not only force her to see the image but also obligate the physician to describe the image to her in detail. Research shows that ultrasound mandates don't change a woman's mind, because a woman has usually thought long and hard about her

decision to terminate her pregnancy.[1] I am currently required by law to ask my patients if they would like to see the ultrasound. In my own experience, many say yes; however, none of my patients have changed their minds after seeing the image. The mandate only serves to increase health care costs by subjecting women to unnecessary tests in these instances. There are many versions of these laws, depending on the state in which the physician practices. How and when a doctor performs an ultrasound prior to an abortion depends on these laws, not what is medically relevant to provide the best health care to the patient.

Ultrasounds are used by women's health professionals for valid medical reasons, including ruling out ectopic pregnancies and determining how far along a pregnancy is. This test is performed prior to the abortion, but there is no medical reason for it to be performed on the same day as the abortion. Ultrasounds should not be used for political or other purposes that fall outside of a standard of medical necessity.

We routinely show the patient an ultrasound image if she asks or if she agrees to view images for educational purposes. Laws that require women to view or hear her ultrasound against her will violate her rights and presume that she is uneducated about what pregnancy means. In no other area of medicine are doctors required to show patients images of their bodies or organs.

2. Bans on the Use of Telemedicine

Many areas of the country have few or no physicians, and health care resources are scarce. In these areas, the ability to counsel patients using modern technology such as video conference calls can actually mean the difference between receiving health care and not. Restrictions on the use of telemedicine means a woman may not have the opportunity to speak to a doctor regarding her pregnancy options: continuing the pregnancy and becoming a parent, continuing the pregnancy to ultimately place the child up for adoption, or terminating the pregnancy. Women deserve to be informed of all of their options in a timely manner, especially when a pregnancy is in question, and this may be safely done via phone or web interface. I see women who have traveled upwards of 500 miles to have an abortion, which is not easy for most women when you consider travel expenses, child care, and time off work. Similar to mandated waiting periods, having women make more than one trip when a tele-consult would suffice is a considerable burden in many areas of the country. *It does nothing to promote patient safety or quality of care.*

Physicians often counsel patients — their own patients and patients of other physicians if on-call — over the phone regarding symptoms, medications, and therapy options. Doctors also deliver the babies of their colleagues' patients as a standard practice, despite childbirth being 14 times riskier than a first trimester abortion. Abortion care is

[1] Kimport K, Preskill F, Cockrill K, Weitz T. Women's perspectives on ultrasound viewing in the abortion care context, Womens Health Issues. 2012 Nov-Dec;22(6):e513-7. doi: 10.1016/j.whi.2012.09.001. Epub 2012 Oct 5, available at http://www.ncbi.nlm.nih.gov/pubmed/23040800.

no different than other health care in this way. Legislative requirements for same-provider counseling or in-person counseling don't advance patient safety or quality of care and only create roadblocks to getting needed care.

In some innovative telemedicine programs, nurses dispense medical abortion medication after an initial, earlier visit with a physician to establish the pregnancy and discuss options. There is no safety reason why women should not be able to receive these medications in a separate office from a nurse after tele-approval by a physician.[2]

3. Regulation of Outpatient Clinics as Ambulatory Surgical Centers

A variety of states have imposed requirements that outpatient clinics conform to the same or similar regulations as an operating room in a hospital. These requirements can include anything from having wider doorways to having equipment in the room for general anesthesia (even though it is not used). These laws force the conversion of a perfectly safe outpatient clinic into a surgical suite that has features above and beyond the needs of the procedures being performed. In many areas of the country, such as mine, requiring abortion clinics that are already up to code and medical standards to meet additional ambulatory surgical center standards will leave those clinics destitute, resulting in women with fewer options for safe care (including many procedures unrelated to abortion care, such as cancer screenings).

Abortion is a procedure that is generally safely done in an outpatient setting. Its potential complication risks are no different than many other outpatient medical procedures performed in a provider's office. State laws should not require abortion care to be performed in settings that meet ambulatory surgical center standards as other medical procedures with similar risk profiles do not face the same requirements. None of the practices in which these other medical procedures are performed (colonoscopy, for example) are required to adhere to more complex surgical center standards.

Hysteroscopy and many assisted reproductive technology procedures such as taking a look inside the uterine cavity with a camera are performed in outpatient clinics that are not surgical centers. The procedures use instruments inside the uterus with the same risks of perforation, hemorrhage, and infection as an abortion procedure. Truth be told, the surgical management of a miscarriage is exactly the same as a first trimester surgical abortion. Exactly the same. I am permitted to perform a dilation and curettage in my clinic as long as it is in the context of a miscarriage, however this is not so in the case of the termination of an otherwise normal pregnancy. The only difference is discrimination against the pregnant person's fertility desires.

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[2] Grindlay K, Lake K, Grossman D. Women's and providers' experiences with medical abortion provided through telemedicine: a qualitative study. Womens Health Issues. 2013 Mar-Apr;23(2):e117-22. doi: 10.1016/j.whi.2012.12.002. Epub 2013 Feb 12, available at http://www.ncbi.nlm.nih.gov/pubmed/23410620.

4. Waiting Periods and Gestational Age Limit Bans

Despite federal law upholding legal access to an abortion until fetal viability, many states are passing their own laws that reduce the gestational age limit for legal abortion procedures. Depending on the state in which she lives, a woman may have an abortion only before 20 or 22 weeks, effectively reducing the time she has to make her life-altering decision. A variety of states have also imposed waiting periods: the length of time between receiving informed consent for an abortion and the time of receiving the actual procedure which may range anywhere from 24 to 72 hours. These may seem like conflicting concepts, and that's because they are. One law effectively requires a more expedited decision process so as not to exceed the reduced gestational age limit, while the other requires a woman to wait longer under the guise of allowing her to make a more thoughtful decision. I take care of many women whose pregnancies have been diagnosed with horrible diseases and conditions incompatible with life, and these women must endure the knowledge of their very desired baby's diagnosis. Often these traumatic diagnoses are made after 20 weeks. She may have the diagnosis near (or past) that state's gestational age limit, which would require her to go to another state to terminate or to carry a pregnancy full-term, undergoing the risks of pregnancy and childbirth, only to watch her newborn suffer and die. Pregnancy, like other conditions such as cancer or heart disease, is time-sensitive and requires expedited treatment, not arbitrary delays imposed by the state.

My state, like many others, requires a waiting period before a woman can have an abortion. These laws are especially intrusive for women seeking pregnancy terminations. They presume women haven't considered their pregnancy options carefully and need "extra time" to be sure. If this is the case, much more dangerous procedures such as organ transplants, brain surgery, plastic surgery, etc. should also require waiting periods. Additionally, these unnecessary regulations and their exceptions are often confusing and may result in requiring a victim of rape or incest to suffer longer because she is waiting for the procedure to be allowed. Being forced to delay the provision of abortion care can also increase the cost and risk of the procedure and thus further delay it, sometimes pushing the pregnancy into the next trimester and bumping up against gestational age bans.

5. Requirements for Admitting Privileges to Local Hospitals

Legislation recently enacted in Texas requires abortion providers to have admitting privileges to a hospital located within 30 miles of their clinic. To understand why this is problematic, it is necessary to understand that, in order to practice medicine at a given hospital, a physician must have admitting privileges to that hospital. This allows the patients a doctor takes care of to be admitted to and cared for as an inpatient of that hospital. Admitting privileges, however, are not required to practice medicine at an outpatient clinic as an outpatient clinic — by its definition — does not have the capacity to provide inpatient care. Many other states have placed similar regulations on abortion providers, resulting in shortages of legal abortion providers when hospitals decide not to

or, in many cases, are disallowed from granting "those" physicians admitting privileges. There is no medical justification for this policy and it is a danger to women's ability to access care.

Once again, in no other specialty are physicians required to have admitting privileges to a hospital in order to perform outpatient procedures. For decades, abortion has been provided safely in an outpatient setting and, if complications arose, the physician would call for an ambulance to take the patient to the hospital. Patients taken to a hospital emergency room are treated whether their provider has admitting privileges or not. With these laws, hospitals wind up under tremendous pressure to deny privileges to abortion providers. In the case of Mississippi, the last clinic may close because the only abortion provider in the state is being denied admitting privileges, leaving women in that state with no in-state provider. Recent legislative efforts in Texas would close several rural clinics in already under-served areas, leaving many women hundreds of miles from care.

The Women's Health Protection Act is a critical response to this ever-increasing onslaught of politically motivated restrictions on abortion care masquerading as health and safety regulations. Thank you for holding this important hearing to shine a spotlight on this alarming trend.

Sincerely,

Leah Torres, MD, MS
Salt Lake City, UT

The Women's Health Protection Act: Beginning to Reclaim a Woman's Right to Choose

Testimony presented by

Ilyse Hogue
President
NARAL Pro-Choice America

On behalf of:
Illinois Choice Action Team
NARAL Pro-Choice Arizona
NARAL Pro-Choice California
NARAL Pro-Choice Colorado
NARAL Pro-Choice Connecticut
NARAL Pro-Choice Maryland
NARAL Pro-Choice Massachusetts
NARAL Pro-Choice Minnesota
NARAL Pro-Choice Missouri
NARAL Pro-Choice Montana
NARAL Pro-Choice New Hampshire
NARAL Pro-Choice New Mexico
NARAL Pro-Choice New York
NARAL Pro-Choice North Carolina
NARAL Pro-Choice Ohio
NARAL Pro-Choice Oregon
NARAL Pro-Choice South Dakota
NARAL Pro-Choice Texas
NARAL Pro-Choice Virginia
NARAL Pro-Choice Washington
NARAL Pro-Choice Wisconsin
NARAL Pro-Choice Wyoming

U.S. Senate
Committee on the Judiciary

July 15, 2014

Members of the Judiciary Committee: I am pleased that you are holding today's hearing and am honored to submit this testimony for the record.

Today the panel will discuss the Women's Health Protection Act (S.1696), a bill that takes a modest but important first step in reclaiming a woman's constitutionally protected right to choose. NARAL Pro-Choice America works not just to support and protect, as a fundamental right and value, a woman's reproductive freedom, but to expand her ability to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion. The Women's Health Protection Act is a modest first step toward ensuring that *all* women have access to reproductive-health care, regardless of their zip code.

Choice Under Attack

In 1973, the Supreme Court held in *Roe v. Wade* that the Constitution's right to privacy encompasses the right to choose whether to end a pregnancy.[1] Well into its fourth decade, *Roe*'s protections remain an essential guarantor of freedom for American women, but in the years since this landmark decision, *Roe*'s protections have been eroded significantly; now, reproductive freedom is in great peril.

After the *Roe* decision, opponents of reproductive freedom, both inside and outside government, organized and undertook a concerted effort to chip away strategically at the right to choose through a series of legislative attacks. At the same time, they succeeded in nominating and confirming anti-choice jurists to the federal bench, all but guaranteeing that, over time, anti-choice state and federal laws would be upheld.

As a result of this strategy, the composition of the nation's highest court shifted dramatically by the time anti-choice legal advocates mounted their next major attack on *Roe* itself. In 1992 in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the newly more conservative court barely reaffirmed the decision in *Roe*, and at the same time sharply curtailed its protections. The *Casey* court abandoned the strict-scrutiny standard of review and adopted a less protective standard that allows states to impose restrictions as long as they do not "unduly burden" a woman's right to choose.[2] Under this new standard, the court cleared the way for state restrictions that it had previously found to violate the right to privacy and effectively invited states to impose new barriers on women's access to abortion.[3] Indeed, under *Casey*'s looser standard, courts have allowed a multitude of state restrictions to be imposed upon reproductive freedom and choice.[4] Abortion bans, mandatory waiting periods, biased-counseling requirements, and medically unnecessary regulations on doctors have unfortunately achieved their intended result: it is more difficult for women to obtain safe, legal abortion care today than it was in 1973, just after the *Roe* decision was handed down.

Now, anti-choice advocates are taking the next step: having already severely restricted women's access to legal abortion nationwide, now they are looking to put the procedure totally out of reach for many American women. Since 1995, state legislatures have enacted 807 anti-choice laws, and the pace accelerated steeply in the past three years. In 2011, after a wave of conservative lawmakers swept into office, state legislatures enacted nearly twice as many anti-choice measures as the previous year, a trend that shows no sign of slowing.

Many of the current restrictions were enacted under the guise of protecting women's health. In reality, however, anti-choice strategists' real goal is to shrink the number of abortion providers and to place so many barriers between women and legal abortion that the procedure is, for all practical purposes, out of reach. The following is a sample of the most prominent recent anti-choice state restrictions sweeping the nation:

- **Abortion Bans**: Since 2011, abortion bans have spread across the states, from those that outlaw abortion before a woman may even know she is pregnant to those that target later abortion. Indeed, 13 states ban abortion after 20 weeks without an adequate health exception.[5] Sponsors admit that abortion bans are part of an alarming, coordinated effort to lure the Supreme Court into dismantling the protections established by *Roe.*

- **Targeted Regulations of Abortion Providers (TRAP)**: Forty-five states and the District of Columbia have laws subjecting abortion providers to burdensome restrictions not imposed on other medical professionals.[6] These measures are an obvious attempt to drive doctors out of practice and make abortion care more expensive and difficult to obtain. Common TRAP regulations include those that limit the provision of care only to doctors, require doctors to convert their practices needlessly into mini-hospitals at great expense, limit abortion care to hospitals, rather than physicians' offices, and/or require doctors to have admitting privileges at a local hospital with nothing requiring facilities to grant such privileges.

- **Mandatory Ultrasound**: Twenty-four states have some type of ultrasound provision on the books with varying degrees of severity; several other states are considering such measures.[7] The most egregious of these laws mandate the performance and review of an ultrasound prior to abortion, regardless of whether the doctor recommends this procedure, and even against a woman's will.

- **Biased Counseling and Mandatory Delays**: Thirty-three states have laws that subject women seeking abortion services to biased-counseling requirements and/or mandatory delays. These laws subject women to a state-mandated lecture and/or materials, typically followed by a delay of at least 24 hours, and in some cases as long as 72 hours. In states with very few providers, a forced delay may result in a woman having to wait as long as another full week for her medical care – which makes it more expensive, increases the risks of the procedure, and in some cases, puts it out of reach altogether.

- **Restrictions on Medication Abortion**: Seventeen states have signed measures into law that restrict the use of medication abortion (also known as RU 486), which provides women with a safe and effective nonsurgical option for early pregnancy termination.[8] Anti-choice politicians fought FDA approval of this abortion option for decades, at every step. Having lost that fight, now they are doing all they can to restrict access to the medication, including restricting how it is delivered, restricting off-label use of the medication,[9] and banning its prescription through telemedicine networks.[10]

The Consequences for Women are Real

These restrictions represent more than just an abstract threat to our constitutional rights. Indeed, the hundreds and hundreds of anti-choice laws imposed on women have had very real and dire consequences:

- Several states only have one abortion provider.[11] In some of those, the doctor flies in from another state and provides services only one day a week.[12] As a result, women seeking abortion care in those states are severely limited in their options.

- In Texas, after the legislature imposed sweeping anti-choice restrictions on women last year, all abortion providers in the lower Rio Grande Valley stopped providing the procedure. Now that vast region has no abortion provider at all.[13] And new research shows that seven percent of all women in Texas who ultimately reached a provider tried first to self-abort.

- Anti-choice legislators have systematically enacted laws across the country banning abortion after 20 weeks. In some cases, such as the American Southeast, they have succeeded in creating entire regions across multiple states where there is no provider who can legally offer later abortion care. Although women need access to later abortion for a variety of reasons, many women who end pregnancies after 20 weeks are doing so because they are facing severe health threats or have recently received a diagnosis of a devastating fetal anomaly.

- NARAL Pro-Choice America's *Who Decides?* publication rates 25 states—half the country—with an F grade for reproductive rights, based on their state laws.[14] According to the Guttmacher Institute, more than half of all women in the country of reproductive age live in the states most hostile to abortion rights.[15]

Pre-*Roe* Hazards Could Reemerge

Effects like those described above could, if the trend is not reversed, signal the reemergence of a grim reality America once knew. When *Roe v. Wade* was decided in January 1973, abortion except to save a woman's life was banned in nearly two-thirds of states.[16] Laws in most of the remaining states allowed only a few additional exceptions.[17] An estimated 1.2 million women

each year resorted to illegal abortion,[18] causing as many as 5,000 annual deaths,[19] despite the known hazards of frightening trips to dangerous locations in strange parts of town, of whiskey as an anesthetic, doctors who were often marginal or unlicensed practitioners, unsanitary conditions, incompetent treatment, infection, hemorrhage, disfiguration, and death.[20]

Doctors who worked in emergency rooms before 1973 saw first-hand the consequences of illegal abortion. Dr. Louise Thomas, a New York City hospital resident during the late 1960s, summed up the dangers of illegal abortion, remembering the "Monday morning abortion lineup" of the pre-*Roe* period:

> What would happen is that the women would get their paychecks on Friday, Friday night they would go to their abortionist and spend their money on the abortion. Saturday they would start being sick and they would drift in on Sunday or Sunday evening, either hemorrhaging or septic, and they would be lined up outside the operating room to be cleaned out Monday morning. There was a lineup of women on stretchers outside the operating room, so you knew if you were an intern or resident, when you came in Monday morning, that was the first thing you were going to do.[21]

Today, because it is legal, abortion is one of the safest medical procedures available. Between 1973 and 1997, the mortality rate associated with legal abortion procedures declined from 4.1 to 0.6 per 100,000 abortions.[22] The American Medical Association's Council on Scientific Affairs credits the shift from illegal to legal abortion services as an important factor in the decline of the abortion-related death rate after *Roe v. Wade*. [23]

In the years since *Roe v. Wade*, hundreds of thousands of American women's lives have been saved. But as new restrictions put safe, legal abortion care out of reach again, the dangers women faced in the years before *Roe* already have begun to reappear.

All Women Should Have Access to Reproductive-Health Care

In the face of these legislative assaults on women's reproductive rights, the Women's Health Protection Act erects a protective barrier. This legislation would establish federal protections against anti-choice measures that purport to protect women's health but are really about taking away their right to choose. In so doing, the Women's Health Protection Act stands for the belief that women can and should be trusted to make these personal, private medical decisions without interference from politicians. Women across the nation welcome this effort to repel the cascade of medically unnecessary and politically motivated restrictions on access to abortion care.

If anti-choice forces prevail in their efforts, Dr. Thomas' experience in the New York hospital wards during the 1960s is likely to be repeated. Studies show that the more restrictions are placed on abortion care, the less accessible the medical procedure becomes. And history

demonstrates that restricted access does not eliminate abortion; rather, in an anti-choice climate, women are forced to seek control over their reproductive lives in any way possible, often risking serious injury or death. Lifting abortion restrictions reduces the number of clandestine, unsafe abortions. Removing unnecessary and inappropriate barriers to abortion care would improve women's health, and spurious claims that abortion services are dangerous should never be used to justify more restrictions on a woman's right to choose.[24] The Women's Health Protection Act stands as a much-needed and long-overdue response to the cascade of state restrictions on abortion care that *endanger*, not protect, women's health.

On behalf of NARAL Pro-Choice America and its more than one million member activists around the country, we urge the committee to ensure that all women, regardless of where they live, are able to realize their constitutionally protected right to choose. Passing the Women's Health Protection Act would be a modest but welcome step in the right direction.

[1] *Roe v. Wade*, 410 U.S. 113, 153 (1973).

[2] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), at 876.

[3] *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), at 881-87.

[4] Between 1995 and 2006, states enacted 512 anti-choice legislative measures—including 45 in 2006 alone. *See generally* NARAL PRO-CHOICE AMERICA & NARAL PRO-CHOICE AMERICA FOUNDATION, *Who Decides? The Status of Women's Reproductive Rights in the United States* (19th ed. 2010), *at* http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/.

[5] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides? A State-by-State Report on the Status of Women's Reproductive Rights*, at 11 (23rd ed. 2013), at www.prochoiceamerica.org/whodecides.

[6] NARAL Pro-Choice America & NARAL Pro-Choice America Foundation, *Who Decides? A State-by-State Report on the Status of Women's Reproductive Rights*, at 19 (23rd ed. 2013), at www.prochoiceamerica.org/whodecides.

[7] NARAL Pro-Choice America, *Forced Ultrasound Legislation is an Egregious Intrusion into Medical Care* (2014).

[8] In addition to internal analysis, data from this section is complemented with data from: Guttmacher institute, *State Policies in Brief: Medication Abortion* (May 1, 2014) at http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf (last visited May 23, 2014).

[9] OHIO R.C. § 2919.123.

[10] W.S.A. § 253.105. In response to the vague and unnecessary restrictions imposed by the new law, Planned Parenthood of Wisconsin and Affiliated Medical Services stopped providing medical-abortion care. Pro-choice allies pursued a legal challenge—which is still ongoing—but the law has been temporarily enjoined and providers resumed providing non-surgical abortion care. Press Release, NARAL Pro-Choice Wisconsin, *Another Wisconsin Health Provider Ceases Medication Abortion in Face of Vague New Regulations* (May 22, 2012) at http://www.wispolitics.com/1006/052212NARAL.pdf (last visited Dec. 11, 2013).

[11] There is only one abortion provider in North Dakota, South Dakota, Arkansas, Mississippi and Missouri. National Abortion Federation, *How Can I Find a Provider Near Me?* at https://www.prochoice.org/Pregnant/find/ (last visited July 10, 2014).

[12] NARAL Pro-Choice America, *Targeted Regulation of Abortion Providers (TRAP) Laws: Decreasing Access, Driving Providers Away* (Jan. 2014) at http://www.prochoiceamerica.org/media/fact-sheets/abortion-access-trap.pdf (last visited July 10, 2014).

[13] Statement of Daniel Grossman, researcher, co-author Texas Policy Evaluation Project, at Ibis Reproductive Health (Mar. 2014) at http://www.ibisreproductivehealth.org/news/documents/Grossmanstatement03_06FINAL.pdf (last visited July 10, 2014).

[14] NARAL Pro-Choice America, *Who Decides?* (Jan. 2014) at http://www.prochoiceamerica.org/assets/download-files/2014-wd-report-card.pdf (last visited July 10, 2014).

[15] Guttmacher Institute, *A Surge of State Abortion Restrictions Puts Providers—and the Women They Sere—in the Crosshairs* (Winter 2014) at http://www.guttmacher.org/pubs/gpr/17/1/gpr170109.html (last visited July 10, 2014).

[16] *Roe*, 410 U.S. at 118-119 n.2.

[17] *See, e.g.*, DEL. CODE ANN., tit. 24, §§ 1790-1793.

[18] Willard Cates, Jr. et al, *Comment: The Public Health Impact of Legal Abortion: 30 Years Later*, 35 PERSP. ON SEXUAL & REPROD. HEALTH 25 (2003); Willard Cates Jr., *Legal Abortion: The Public Health Record*, 215 SCIENCE 1586 (1982); Richard Schwarz, SEPTIC ABORTION 7 (1968).

[19] The estimated number of deaths from illegal abortion services (e.g. 5,000) has been derived from the findings of several studies. The following is a summary of these studies: "Difficulty as it is to accumulate statistics in this area, a surprising similarity has been noted in various studies independently made within the last thirty years. If general trend observed is accepted, without becoming sidetracked in disputes over exact numbers of methodology, we must consider the probability that more than one million criminal abortions will have been performed in the United States in 1962, and more than five thousand women may have died as a direct result." Zad Leavey & Jerome M. Krummer, *Criminal Abortion: Human Hardship and Unyielding Laws*, 35 S. CAL. L. REV. 124 (1962) (citing to Gebhard, et al, PREGNANCY, BIRTH AND ABORTION 136-137 (1958); Frederick Taussig, ABORTION SPONTANEOUS AND INDUCED: MEDICAL AND SOCIAL ASPECTS 25 (1936); Marie Kopp, BIRTH CONTROL IN PRACTICE 222 (1934); Stix, *A Study of Pregnancy Wastage*, 13 MILBANK MEMORIAL FUND QUARTERLY 347, 355 (1935); MODEL PENAL CODE § 207.11, comment, p. 147 (Tent. Draft No. 9, 1959.). "It has been estimated that as many as 5,000 American women die each year as a direct result of criminal abortion. The figure of 5,000 may be a minimum estimate." Richard Schwarz, SEPTIC ABORTION 7 (1968) (citing to Taussig, 23-28, which discusses the original mathematical formula used for determining that somewhere between 8,000 and 10,000 women died each year from illegal abortion.).; "One recent study at the University of California's School of Public Health estimated 5,000 to 10,000 abortion deaths annually." Lawrence Lader, ABORTION 3 (1966) (also citing to Edwin M. Gold et al, *Therapeutic Abortions in New York City: A Twenty-Year Review*, in New York Dept. of Health, Bureau of Records and Statistics (1963), which discussed Dr. Christopher Tietze's estimate of nearly 8,000 deaths from illegal abortion annually in the United States. The estimate was based on the number of illegal abortions in New York City, the only major municipality keeping abortion statistics.); "[M]ore than five thousand women may have died as a direct result [of criminal abortion in the United States in 1962]." Zad Leavy & Jerome M. Kummer, *Criminal Abortion: Human Hardship and Unyielding Laws*, 35 S. CAL. L. REV. 123, 124 (1962); "Taussig and others have concluded that the abortion death rate during the late 1920s was about 1.2% and amounted to over 8,000 deaths per year." Russell S. Fisher, *Criminal Abortion*, *in* Harold Rosen, THERAPEUTIC ABORTION, MEDICAL PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL, AND RELIGIOUS CONSIDERATIONS 8 (1954).

[20] Walter Dellinger & Gene B. Sperling, *Abortion and the Supreme Court: The Retreat from* Roe v. Wade, 138 U. PA. L. REV. 83, 117 (Nov. 1989).

[21] Carole Joffe, DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER *ROE V. WADE* 60 (1995).

[22] Laurie D. Elam-Evans et al., Centers for Disease Control & Prevention, *Abortion Surveillance – United States, 1999*, 51 MORBIDITY & MORTALITY WEEKLY REP. 1, 28, tbl. 19 (2002).

[23] Council on Scientific Affairs, American Medical Association, *Induced Termination of Pregnancy Before and After* Roe v Wade*: Trends in the Mortality and Morbidity of Women*, 268 JAMA 3231, 3232 (1992).

[24] Anne Tinker & Marjorie A. Koblinsky, *World Bank Discussion Papers: Making Motherhood Safe,* at 40-41 (1993).

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July 15, 2014

The Honorable Patrick Leahy, Chairman
The Honorable Chuck Grassley, Ranking Member
US Senate Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510

RE: Full committee hearing, "S 1696: The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights"

Written testimony in support of S 1696, submitted electronically.

Dear Chairman Leahy and Ranking Member Grassley:

The National Council of Jewish Women (NCJW) is a grassroots organization of volunteers and advocates who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children and families, and by safeguarding individual rights and freedoms.

Founded in1893, NCJW has a long history of strong support for the protection of every female's right to reproductive choices, including safe and legal abortion; access to contraception; and the elimination of obstacles that limit reproductive freedom. The ninety-thousand members, volunteers, and supporters of NCJW affirm abortion as an essential component in the spectrum of comprehensive, confidential, affordable reproductive health services that must be accessible to women, regardless of age, ability to pay, or other factors. Ensuring that all women have access to comprehensive reproductive health services, particularly including abortion, is essential to a woman's health, economic opportunity, and to her full equality.

We believe that each woman must have the right to exercise her own moral judgment when making personal decisions, including those that affect her reproductive life. Reproductive freedom is integral to a woman's religious liberty. A woman must be able to make decisions about her reproductive health according to her own religious beliefs, moral values, or faith tradition. For a woman to be able to make her own decisions, she must have access to the care and services she needs.

NCJW is deeply troubled that, despite each woman's *de jure* constitutional right to end a pregnancy, the ability of a woman in the United States to access abortion has become dependent upon where she lives as well as her income. This landscape obstructs reproductive justice, the ability of a woman to fully exercise her reproductive rights regardless of her age, income, race, or other factors. State legislators have advanced restrictions that make abortion more difficult for women to access, and for health professionals to provide. These restrictions harm women's health, economic security, and religious liberty; and fall hardest on women and families who are marginalized in our communities, particularly those who are poor or low income and people of color.

Given this reality, the Women's Health Protection Act is urgently needed to restore a woman's ability to access abortion no matter where she lives, and restore her ability to truly make moral decisions about her health and well-being without political interference.

The Women's Health Protection Act would make unlawful any policy or regulation which singles out abortion services for limits that are more burdensome than those imposed on medically comparable procedures; those which do not significantly advance women's health or the safety of abortion care; and which make abortion services more difficult to access. Over the past several years, conservative state lawmakers have intensified their attacks on access to abortion, reaching unprecedented levels. More state restrictions have been enacted in the past four years than in the prior decade[1]. Recent trends include targeted regulation of abortion providers (or TRAP laws), placing medically unnecessary, onerous restrictions on clinics and providers; banning the use of telemedicine to provide abortion or forcing providers to adhere to outmoded regimens in the provision of medication abortion; and pre-viability or "later abortion" limits that ban abortion at an arbitrary gestational limit, among others. Taken together, more than half — or 56-percent[2] — of all women of reproductive age in the US currently live in states "hostile to abortion," where care is difficult or nearly impossible to access.

Such restrictions do not reduce the need for this abortion, but they erode women's rights and risk harming women and their families with far-reaching consequences. For many women, barriers to abortion only serve to make complex decisions even more difficult. This could have been the case for Dr. Julie Bindeman, a clinical psychologist who practices in Rockville, Maryland, who needed abortion later in pregnancy. In March 2014, Julie spoke to NCJW's 46th national convention about her experience, when our organization honored her with a "Women Who Dared" award for her courage in reproductive justice advocacy.

Julie and her husband had one son and wanted another child. Her first pregnancy in this effort resulted in miscarriage, a devastating outcome for her and her family. She was happy when she became pregnant after a second try, but the experience did not begin as she anticipated. She experienced blood clots and was put on "pelvic rest" for a week. Eventually, additional tests showed her developing fetus was

[1] Heather Boonstra and Elizabeth Nash, "A surge of state abortion restrictions puts providers – and the women they serve – in the crosshairs," *Guttmacher Policy Review,* Winter 2014 (http://www.guttmacher.org/pubs/gpr/17/1/gpr170109.html)
[2] Ibid.

healthy, so she went to her doctor for a 20-week ultrasound eager to learn its gender. The ultrasound showed she was having a boy, but the additional information gained from the scan showed complications. As Julie explains:

> *Our OB…told us that the ultrasound showed our child's brain ventricles were nearly twice the size they should be. My husband and I sat in stunned silence, and we slowly began to cry deep sobs of pain.*
>
> *…We then met with several specialists to get second and third opinions [from experts at Children's Hospital], including a radiologist, pediatric neurosurgeon, and genetic counselor. Each specialist confirmed the horrible news: our best case scenario, if the baby even survived to term, was that our son would have the developmental ability of a two-month-old.*
>
> *The diagnosis was ventriculomegaly and hydrocephalus, with likelihood of ancephaly [severe brain malformations]. We were told our two options: we could terminate the pregnancy, or carry to term and see what happened. I asked point blank about the chances of a miracle. The doctors at [Children's Hospital] tend to be 'hope-givers,' but for my question they had no optimistic outcome to share.*
>
> *We decided to end the pregnancy, [making a decision the day before Thanksgiving.] I somehow made it through the holiday completely in a fog, trying to ignore the kicks that were getting stronger. These kicks had no conscious thought behind them, nor would any of my son's actions. [While Maryland allows surgical abortion at this stage of pregnancy, there were no providers in the state.] I wanted to be around family, so we decided to deliver locally. My husband and I went to the hospital and worked with the medical team to induce labor. My son died soon after delivery and I was discharged the next day. I was 21 weeks gestation.*

For Julie, ending her pregnancy was an emotionally fraught and painful decision. Thankfully, because she lived in Maryland, this decision remained hers to make. Had Julie lived in one of the 10 states that now ban abortion at about 20 weeks postfertilization[3], she might have been forced to carry her pregnancy to term. The Women's Health Protection Act would help women and families facing similar situations by making unlawful bans on abortion based on arbitrary gestational limits.

Julie's story further illustrates that every pregnancy is different. Not every pregnancy ends the way a family hopes it will; some end in miscarriage, sometimes a woman develops health complications, and in some cases, women hear difficult news from their doctors that something is wrong with their pregnancy. Just as each pregnancy is different, so is every woman's personal circumstances. According to the Guttmacher Institute, one in three women will have an abortion in her lifetime; each of their stories are as different as the lives they live. A woman may be facing an unintended pregnancy and knows she is not ready to become a parent; seeking to build her family, but facing difficult news about a severe fetal anomaly; or, already a mother who knows she cannot afford to raise another child. No matter her

[3] Guttmacher Institute, "States continue to enact abortion restrictions in first half of 2014, but at a lower level than in the previous three years," News in Context, July 8, 2014 (http://www.guttmacher.org/media/inthenews/2014/07/08/index.html)

circumstance, a women must be free to make personal decisions about her health and reproductive life without political interference.

Current state interference in these decisions harms some women more than others, and can jeopardize their economic security. For example, women and families struggling to make ends meet, who today are disproportionately people of color, face steeper challenges to overcome restrictions on access to care than their neighbors with greater resources. Access barriers can impose great financial burdens on women and families, with far-reaching consequences: a woman may be forced to delay needed care, unnecessarily increasing the risk of an otherwise safe procedure, or shut off her phone or utilities just to pay for the care she needs. Indeed, recent studies show that a woman who seeks abortion services but is denied is three times more likely to fall into poverty than a woman who can access this care[4]. This threat to women's financial security and independence is another critical reason why we support the Women's Health Protection Act.

Safe, timely, accessible care is another reason why women need this legislation. Julie was able to obtain the quality care she needed near her home and family, but many women are seeing abortion services in their communities shrink dramatically or disappear altogether. A survey of clinics, state health departments and local abortion rights advocacy organizations conducted by The Huffington Post found that "at least 54 abortion providers across 27 states have shut down or ended their abortion services in the past three years" (from 2010-2013) primarily as a result of TRAP laws' onerous requirements[5]. Additionally, the Guttmacher Institute reports that nearly 60-percent of women of reproductive age now live in one of the 26 states with one or more TRAP restrictions[6]. Such statistics are appalling. When a woman decides to obtain an abortion, it is critical that she have access to safe, timely medical care, the availability of which should not depend on where she lives. The Women's Health Protection Act would help reverse this dangerous trend, ensuring that women across the country can access needed care.

Another critical reason why women need this legislation is the protection of women's religious liberty and moral agency. Julie was able to make a decision that was best for her and her family, in the context of her own religious, moral, and ethical beliefs and values. Despite it being their constitutional right, women in other states may not have that choice in reality, given restrictions on access to care. As a result, women who seek abortion, but are denied, see their religious liberty eroded along with their reproductive freedom.

As a faith-based women's organization, NCJW understands that those who would restrict women's access to abortion and other reproductive health services are often motivated by their religious beliefs. However, it is essential to recognize that there is no single religious teaching on these issues. The Jewish tradition teaches that, during a pregnancy, the life of the mother takes precedence over the potential life

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[4] Joshua Lang, "What Happens to Women Who are Denied Abortions?" *New York Times*, June 12, 2013 (http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html?pagewanted=all&_r=1&)
[5] Laura Bassett, "Anti-abortion laws take dramatic toll on clinics nationwide," The Huffington Post, August 8, 2013 (http://www.huffingtonpost.com/2013/08/26/abortion-clinic-closures_n_3804529.html)
[6] Guttmacher Institute, "States continue to enact abortion restrictions in first half of 2014, but at a lower level than in the previous three years," News in Context, July 8, 2014 (http://www.guttmacher.org/media/inthenews/2014/07/08/index.html)

of a fetus, particularly as "Judaism does not believe that personhood and human rights begin with conception, but with birth."[7] Different religions have differing views on when life begins, on attitudes towards abortion, and other reproductive health issues. Even within religions, there can be varying opinions.

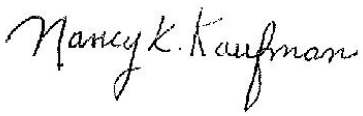
Our nation has answered the questions of this pluralism by upholding the key, founding principle and constitutional right of religious freedom. NCJW is committed ensuring that every person be given due respect for holding their own religious beliefs with regard to abortion and other healthcare. But we firmly believe it is unjust to privilege one view over another by enacting laws that restrict access to legal healthcare, in order to deny a woman from making her own faith-informed decisions about her health and family. Each person of faith, and those who do not follow a religious tradition, must be allowed to make their own faith or conscience-informed decision. For the legislature to mandate one religion's views on this very personal issue is to restrict religious liberty for all.

The decision to choose adoption, end a pregnancy, or become a parent are deeply personal. They may be complicated and challenging, as for NCJW honoree, Dr. Julie Bindeman. But no matter a woman's circumstances or where she lives, our lawmakers have a duty to protect her constitutional right to make this decision, based on her own religious beliefs and moral values and in the context of her life.

State legislators are eroding women's rights and freedoms. They are placing women's health, well-being, and economic security at risk as they aggressively enact unprecedented levels of restrictions on abortion. It is time for Congress to step in to provide women and their families with the federal protection they urgently need.

NCJW urges Congress to swiftly pass the Women's Health Protection Act and see it enacted into law. Thank you for your consideration of this testimony.

Sincerely,



Nancy K. Kaufman, CEO
National Council of Jewish Women

[7] The Rabbinical Assembly, "Resolution on reproductive freedom," February 2007, (http://www.rabbinicalassembly.org/resolution-reproductive-freedom)

national network of abortion funds
Connecting Rights to Resources

July 22, 2014

The Honorable Patrick Leahy, Chair
The Honorable Charles Grassley, Ranking Member
Senate Judiciary Committee
Washington, DC 20510

Dear Chairman Leahy and Ranking Member Grassley:

Thank you for the opportunity to submit this statement on behalf of the National Network of Abortion Funds in support of S. 1696, the Women's Health Protection Act, on which a hearing was held before the Senate Judiciary Committee on July 15, 2014.

The National Network of Abortion Funds was founded in 1993 and includes more than 80 abortion funds in the United States, Mexico, Canada and the United Kingdom. Every day, our funds serve women who need abortion care and are struggling financially. Each year we help over 24,000 women obtain abortion care they otherwise would not be able to obtain. We know first-hand the impact of restrictions that make abortion more unavailable and unaffordable.

Restrictions on abortion create significant obstacles for women seeking care. This impact falls most on women who are struggling financially to make ends meet. Because of the connection between racial discrimination and economic disadvantages, they are disproportionately more likely to be women of color and immigrant women, and are often younger as well. Women with lower socioeconomic status – specifically those who are least able to afford out-of-pocket medical expenses – already experience disproportionately high rates of adverse health conditions. Denying access to abortion care only exacerbates existing health disparities.[1]

Studies show that most Americans do not have enough savings to cover a financial emergency, which means they have to borrow, sell or pawn personal items, or divert money from another financial obligation to cover emergencies such as an unexpected health care need.[2] This,

[1] Foster DG, Roberts SCM and Mauldon J, Socioeconomic consequences of abortion compared to unwanted birth, abstract presented at the annual meeting of the American Public Health Association, San Francisco, Oct. 27–31, 2012. Available at https://apha.confex.com/apha/140am/webprogram/Paper263858.html.

[2] National Foundation for Credit Counseling, Majority of Americans do not have money available to meet an unplanned expense, news release, Aug. 15, 2011. Available at http://www.nfcc.org/NewsRoom/newsreleases/FLOI_July2011Results_FINAL.cfm, accessed Aug. 20, 2013. Cited in Boonstra, HD, "Insurance Coverage of Abortion: Beyond the Exceptions for Life Endangerment, Rape and Incest." *Guttmacher Policy Review*, Vol. 16, No. 3, 2013.

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combined with the growing challenges in finding affordable abortion care, make it increasingly difficult for women to safely and legally end their pregnancies.

Abortion restrictions that increase the delays or cost of an abortion force many women to delay their procedure for as long as two to three weeks. The cost and potential health risks of the procedure increase the longer they wait.[3]

Not only do these laws create more burdens for low-income women, but they contribute to poverty. Studies show that a woman who seeks an abortion but is denied is three times more likely to fall into poverty than one who is able to get an abortion.[4]

The Women's Health Protection Act, which dismantles many of the barriers for women seeking abortion services, will contribute to a healthier country in which every woman can get affordable and available pregnancy related care, including birth control, maternal care, and abortion services. While it addresses some of the important barriers to care, it does not address one of the most formidable, which is insurance coverage, especially through Medicaid.

The Hyde Amendment has banned the federal government from covering abortion for women enrolled in Medicaid, or Indian Health Services, women in the military, Peace Corps or in federal prisons, except in cases of rape, incest, or endangerment to the life of the woman. These policies unjustly interfere with a woman's ability to make the decision best for her and her family.

We applaud the important and necessary progress the Women's Health Protection Act will make for the health, rights, and dignity of women and families. And we urge you to work to repeal harmful insurance coverage restrictions that also interfere with the self-determination of so many in our nation. We urge you to pass the Women's Health Protection Act because every woman deserves the ability to make her own important life decisions about pregnancy, wherever she lives and however much she makes.

Sincerely,

Stephanie Poggi
Executive Director

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[3] National Foundation for Credit Counseling, Majority of Americans do not have money available to meet an unplanned expense, news release, Aug. 15, 2011. Available at http://www.nfcc.org/NewsRoom/newsreleases/FLOI_July2011Results_FINAL.cfm, accessed Aug. 20, 2013. Cited in Boonstra, HD, "Insurance Coverage of Abortion: Beyond the Exceptions for Life Endangerment, Rape and Incest." *Guttmacher Policy Review*, Vol. 16, No. 3, 2013.

[4] Foster DG, Roberts SCM and Mauldon J, Socioeconomic consequences of abortion compared to unwanted birth, abstract presented at the annual meeting of the American Public Health Association, San Francisco, Oct. 27–31, 2012. Available at https://apha.confex.com/apha/140am/webprogram/Paper263858.html.

national partnership for women & families
Because actions speak louder than words.

"S. 1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights"

Testimony submitted by

Debra Ness, President
Sarah Lipton-Lubet, Director of Reproductive Health Programs
Melissa Safford, Policy Advocate

U.S. Senate Judiciary Committee
Chairman Patrick Leahy and Ranking Member Charles Grassley

July 15, 2014

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The National Partnership for Women & Families is a nonprofit, nonpartisan 501(c)(3) organization located in Washington, D.C. We have worked tirelessly for over forty years to expand access to quality, affordable health care for all Americans that includes comprehensive reproductive health services; to eliminate discrimination in the workplace; and to enable women and men to meet the dual demands of work and family. The National Partnership strongly supports S. 1696, the Women's Health Protection Act, and we urge the Senate to pass this important legislation.

The Women's Health Protection Act Would Begin to Reverse the Devastating Impact of Years of Callous Attacks on Women's Access to Abortion Care.

Women's access to abortion care is under attack in states across the country. According to the Guttmacher Institute, from 2011 to 2013, states enacted more abortion restrictions than in the entire previous decade. In 2013 alone, 22 states passed 70 abortion restrictions, making it increasingly difficult for health care providers to offer abortion care and for women to access this vital health care service. While states have an important role to play in regulating the medical profession, when those regulations do not comport with medical standards or when they directly interfere in the relationship between women and their health care providers, lawmakers have abused their authority. Legislatures pass these laws under the guise of protecting women's health, but in reality, they jeopardize it. The bottom line is that these laws make abortion care more difficult to access, and women's health and safety is threatened when they are unable to get the health care they need.

All women deserve access to affordable, high-quality care and the treatment options that best meet their needs. Yet laws that place onerous restrictions on abortion care make abortion more difficult to access, especially for low-income women. They can also force health care providers to choose between adhering to their ethical and professional obligations to provide the highest standard of care and following restrictions enacted in pursuit of a political agenda. The Women's Health Protection Act would reverse this distributing trend by ensuring that women can make personal health care decisions for themselves regardless of where they live.

The Women's Health Protection Act Would Protect the Patient-Provider Relationship by Ensuring that Medical Professionals are Able to Make Decisions Based on Their Best Medical Judgment.

There is a strong national consensus that quality care should be evidence-based and patient-centered, and should improve health outcomes. Health care providers, the federal government, state and local governments and patient advocates across the country are all investing significant resources in promoting high-quality care. According to the Institute of Medicine – an independent, nonprofit organization that serves as the health arm of the National Academy of Sciences – *quality care is care that*

meets the patient's needs and is based on the best scientific knowledge. It is the right care at the right time in the right setting for the individual patient. However, when it comes to regulation of abortion care, things are moving in the opposite and wrong direction. States are enacting restrictions that undermine the high-quality, patient-centered care that health care providers and advocates strive to achieve.

For example, thirteen states have passed laws mandating an ultrasound before an abortion. While ultrasound is frequently used as a standard part of abortion care, best practices and medical ethics indicate that it should be administered only when the health care provider believes it is necessary for medical purposes or when the patient requests it. Laws requiring a provider to administer an ultrasound regardless of the patient's individual circumstances, along with other state-directed mandates such as forcing a provider to display the image and describe it – even when a woman objects – undermine quality care. It is a violation of medical standards to use a procedure to influence, shame or demean a patient. These laws usurp the medical judgment of health care providers and ignore the needs and best interests of women.

Another example of these harmful laws include those that prohibit a provider from using evidence-based standards to administer medication abortion or ban the use of telemedicine to provide this care. Eighteen states have passed such restrictions, which have no basis in, or are contrary to, medical evidence. These laws restrict a woman's ability to access appropriate, evidence-based care in a timely manner and in the most appropriate setting, undermining quality care.

Medication abortion is a safe, nonsurgical abortion method in which medications are used to end a pregnancy. This method is medically indicated for certain women, and others may choose it because it provides them more control and it is more private. This can be particularly important for survivors of sexual assault who may want to avoid an invasive procedure. Yet several states have prohibited the use of evidence-based prescribing when it comes to medication abortion. These states require providers to adhere to an outdated protocol that is found on the label for the medication abortion drug, as initially approve by the FDA in 2000, rather than allowing providers to administer it according to the most up-to-date research.

It is common practice – and often representative of the best quality care – for providers to follow the medical community's evidence-based regimen in lieu of the protocol found on a medication's label. The American Medical Association has voiced its "strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion." Yet some laws restricting medication abortion make it a crime for a health care provider to follow the most up-to-date standard of care.

Years of use in the field, as well as additional research and clinical studies, allow doctors to learn much more about a drug and adjust the standard of practice based on

the most current scientific evidence. The best practices for care consistently evolve as new evidence is collected, while an FDA label will typically not be updated unless the manufacturer was to advertise the drug for a new purpose and, even then, only when the manufacturer has gone through a complicated and expensive updating process.

Major medical organizations across the United States and the world have endorsed the more recently developed, evidence-based regimen for medication and abortion. As the American College of Obstetricians and Gynecologists and the American Medical Association have jointly stated, "evidence-based regimens have emerged that make medical abortion safer, faster, and less expensive, and that result in fewer complications as compared to the protocol approved by the FDA over 13 years ago," adding that the evidence-based regimen is "superior" to the FDA protocol.

The other way states are restricting access to medication abortion is by prohibiting it from being provided using telemedicine. Telemedicine is a safe way to make health care more accessible, especially to women in underserved areas. Consultation through video conferencing, where a patient interacts with a remote provider is a common and growing method of providing care. When medication abortion is administered via telemedicine, a woman first has a face-to-face meeting with a trained medical professional at a health care clinic where she receives information about the medication and the process. The woman then meets with a physician via a video conference system to review her medical records and ask questions. Once the medical visit is completed, the physician authorizes the clinic to administer the medication.

The American College of Obstetricians and Gynecologists has determined that medication abortion "can be provided safely and effectively via telemedicine with a high level of patient satisfaction," and that laws banning telemedicine are contrary to medical evidence. Studies comparing face-to-face medication abortion provision with medication abortion via telemedicine show equivalent effectiveness and rates of positive patient experience. Telemedicine patients particularly valued being able to receive abortion care at clinics closer to their homes.

The Women's Health Protection Act would prohibit these onerous restrictions that interfere in the patient-provider relationship, as well as others that target abortion care and serve only to restrict access to this important health care service for women.

Lawmakers Should Acknowledge and Support Health Care Providers' Ethical and Professional Obligation to Put Their Patients First, and Should Strive to Improve the Quality of Care – Not Undermine it.

The National Partnership recognizes that states have an appropriate role to play in regulating the medical profession, but stepping into the exam room with an ideological agenda, overriding providers' medical judgment, ignoring patients' needs, and erecting barriers to constitutionally protected reproductive rights is an unacceptable overreach.

The National Partnership urges all lawmakers to reject regulations or actions that inappropriately infringe on the relationship between patients and their health care providers, or that require providers to violate accepted, evidence-based medical practices and ethical standards. Laws that are based on ideology and not sound medical evidence, and that single out abortion care for restrictions that are more burdensome than those imposed on medically comparable care or make abortion care more difficult to access, must be taken off the books.

Conclusion

All women deserve access to high-quality abortion care and the treatment options that best meet their needs without unnecessary, ideological, and political barriers. The National Partnership for Women & Families urges the Senate to pass S. 1696, the Women's Health Protection Act, to protect women's health and to ensure that health care decisions are made by women and their health care providers – not by politicians.

Source: *Bad Medicine: How a Political Agenda is Undermining Women's Health Care*, National Partnership for Women & Families, July 2014.

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

Testimony Submitted for the Record

Judy Waxman
Vice President for Health and Reproductive Rights
National Women's Law Center

Hearing on S. 1696, The Women's Health Protection Act of 2013
U.S. Senate Committee on the Judiciary

July 15, 2014

Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. The Center utilizes a wide range of tools – including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education – to achieve gains for women and their families, including protecting and advancing women's reproductive health and rights.

The National Women's Law Center is writing in strong support of S. 1696, the Women's Health Protection Act. We urge the Senate to pass this legislation.

Women Have a Constitutional Right to Decide Whether to Have an Abortion

Over forty years ago, the Supreme Court held that the constitutional right to privacy includes a woman's right to decide whether to have an abortion.[1] The Supreme Court's recognition of that right has made a significant difference in women's lives, and women and their families have come to rely upon it. As the Supreme Court said when it reaffirmed *Roe* in its 1992 decision *Planned Parenthood v. Casey*, "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."[2]

State Politicians are Increasingly Encroaching upon that Right, Leaving a Woman's Constitutional Right Dependent upon the State in which She Lives

Despite *Roe*'s promise to women, anti-abortion politicians in the states have continued their push to further challenge the core constitutional protections for a woman's decision to have an abortion. In the last three years alone, states have passed a record number of abortion restrictions – more than in the entire previous decade.[3] These laws are a dangerous overreach into a woman's personal medical decisions, and are creating a country where a woman's constitutional right to abortion depends upon her zip code.

Some of these laws are blatant attempts to override *Roe v. Wade* and the constitutional parameters established by the Supreme Court. For example, the Court made it clear in *Roe v. Wade*, and reaffirmed in *Planned Parenthood v. Casey*, that states cannot ban abortion prior to viability. Yet, in 2013, North Dakota passed a law banning abortion as early as six weeks of pregnancy, which is before most women even know they are pregnant, and Arkansas passed a law banning abortion at 12 weeks of pregnancy.[4] The Women's Health Protection Act reaffirms that under federal law, as under the U.S. Constitution, these blatant attempts to take away abortion prior to viability are unlawful.

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[1] Roe v. Wade, 410 U.S. 113 (1973).

[2] Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 856 (1992).

[3] *Laws Affecting Reproductive Health and Rights: 2013 State Policy Review*, GUTTMACHER INSTITUTE, http://www.guttmacher.org/statecenter/updates/2013/statetrends42013.html.

[4] H.B. 1456, 63d Leg. Assemb., Reg. Sess. (N.D. 2013) (codified as N.D. CENT. CODE § 14-02.1-05.1 to -.2 (2013)), *invalidated by* MKB Mgmt. Corp. v. Burdick, No. 1:13-CV-071, 2014 WL 1653201 (D.N.D. Apr. 16, 2014), *appeal filed*, No. 14-2128 (8th Cir. May 14, 2014); S.B. 134, 89th Gen. Assemb., Reg. Sess. (Ark. 2013) (codified as ARK. CODE ANN. § 20-16-1301 to -1307 (2013)), *invalidated in part by* Edwards v. Beck, No. 4:13CV00224SWW, 2014 WL 1245267, at *4 (E.D. Ark. Mar. 14, 2014) (holding twelve-week ban on abortion unconstitutional and permanently enjoining enforcement of § 20-16-1304), *appeal filed*, No. 14-1891 (8th Cir. Apr. 16, 2014).

Many of the state laws being passed restrict access to abortion not by banning it outright but by singling out the provision of abortion services for restrictions that are more burdensome than those imposed on other medical procedures and making it more difficult or expensive to obtain. In fact, 26 states regulate abortion providers beyond what is necessary to ensure patient safety.[5]

For example, laws requiring abortion providers to obtain medically unnecessary hospital admitting privileges. There is no medical reason for these laws, and plans are already in place in the rare case of an emergency. That is why groups like the American Medical Association and the American Congress of Obstetricians and Gynecologists oppose these laws, which are written with the goal of making access to safe and legal abortion hard or even impossible.

In Mississippi, where the state passed an admitting privileges law in 2012, doctors who provide abortions at the sole abortion clinic in the state were denied privileges at every hospital to which they applied.[6] Making it clear that this law was not about protecting women, the author of the legislation said, "The intent of the legislation is to cause fewer abortions. So if the [one clinic left in Mississippi] had to shut down, then I think it is a positive day for the unborn."[7] Fortunately, a federal district judge blocked the law while the lawsuit moves forward, so that Mississippi women who need abortion care are not forced to leave the state.[8] However, women living in the Texas Rio Grande Valley are not so lucky. The Fifth Circuit Court of Appeals upheld Texas's admitting privileges requirement, despite the fact that it is causing clinics to close and forcing these women to travel 150 miles to access an abortion provider.[9]

The Women's Health Protection Act will make it clear that such restrictions – and others that unfairly target only abortion providers, make abortion more difficult for women to access, or have no medical or clinical justification – are unlawful.[10] This will establish a clear standard across states, and help protect the constitutional right to privacy of each woman, no matter where she lives.

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[5] *State Policies in Brief: Targeted Regulation of Abortion Providers*, GUTTMACHER INST. (July 1, 2014), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.

[6] Associated Press, *Legal Woes for Mississippi's Only Abortion Clinic*, USA TODAY, Jan. 11, 2013, http://www.usatoday.com/story/news/nation/2013/01/11/abortion-mississippi-women-clinic/1828289.

[7] M.J. Lee, *Bill Dooms Only Miss. Abortion Clinic*, POLITICO (Apr. 5, 2012), http://www.politico.com/news/stories/0412/74871.html#ixzz37fV2gAwW.

[8] A federal judge prevented the law from going into effect while the lawsuit, *Jackson Women's Health Organization v. Currier*, proceeds. *See* Press Release, Center for Reproductive Rights, Federal Judge Blocks All Enforcement of Mississippi Admitting Privileges Requirement (Apr. 15, 2013), http://reproductiverights.org/en/press-room/federal-judge-blocks-all-enforcement-of-mississippi-admitting-privileges-requirement. The state appealed the temporary injunction, and the Fifth Circuit heard arguments in the case in April 2014. Press Release, Center for Reproductive Rights, Fifth Circuit Considers Mississippi Law Designed to Shutter Last Clinic in the State (Apr. 28, 2014), http://reproductiverights.org/en/press-room/Fifth-Circuit-Considers-Mississippi-Law-Designed-to-Shutter-Last-Clinic-in-the-State.

[9] Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583, 597 (5th Cir. 2014).

[10] Restrictions such as requiring women to undergo a mandatory ultrasound or visit anti-abortion crisis pregnancy centers and those that put medically unnecessary restrictions on the use of medication abortion would also be unlawful under Sec. 4(a) of the Women's Health Protection Act.

Conclusion

In the four decades since Roe v. Wade was decided, women and their families have come to rely upon the fundamental constitutional protection of a woman's decision to have an abortion. Although *Roe* – and the right to privacy and liberty upon which it relies – has been repeatedly reaffirmed by the Supreme Court, attacks upon the right continue. As these attacks on women's access to reproductive health care continue unabated, the ability of women to obtain the health care they need has never been at greater risk. That is why the National Women's Law Center supports the Women's Health Protection Act, which is necessary to enshrine in federal law the principle that each woman, no matter in which state she lives, has access to safe, legal abortion services as guaranteed under the U.S. Constitution. The National Women's Law Center strongly urges the Committee and Congress to pass S. 1696.

NYAAF
New York Abortion Access Fund

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 22, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

The New York Abortion Access Fund writes in support of the Women's Health Protection Act, which protects the ability to obtain abortion services by dismantling many of the barriers that currently exist for people seeking this important healthcare. Every individual faces their own unique circumstances, challenges, and potential complications, and must be able to make her own decisions based on their doctor's advice, their personal values, and what's best for the individual and her family. Everyone needs affordable and accessible pregnancy-related care, including abortion, regardless of where they live and notwithstanding their economic, political, or personal situation. We urge Congress to pass the Women's Health Protection Act, and uphold our nation's promise of equal rights under the Constitution, so that everyone can make personal reproductive health decisions with dignity.

Despite the clear constitutional rights established in *Roe v. Wade*, a growing number of individuals are finding it increasingly challenging to access abortion care. In our communities throughout the country, it has become extremely difficult for people to safely and legally end a pregnancy because states have enacted laws singling out reproductive health care for onerous regulations that are not imposed on other areas of medicine. Low income people, people of color, and young people are more likely to experience unintended pregnancy and therefore more likely to need abortion services than affluent white individuals: these outcomes are caused by socioeconomic disadvantage, lack of access to family planning, persistent forms of racism and other structural barriers to care, and mistrust in a medical system that has a history of discrimination and disparate treatment.[i] As a result, restrictions on abortion care amplify existing health disparities, disproportionately harming people who already face barriers to accessing quality health care, due to their socioeconomic status, gender, and race.

We can protect a person's health and well-being by ensuring that everyone has access to the reproductive health care they need. Restrictions imposed on health care providers and abortion services impede meaningful access to essential services to the detriment of public health — particularly for individuals who are already disadvantaged by systems of economic and racial oppression. According to a recent survey of state health departments, more than fifty abortion clinics have closed or stopped providing abortion since the 2010 onslaught of legislative attacks

on reproductive health services began around the country.[ii] In Mississippi, for example, a medically unnecessary admitting privileges law creates a significant obstacle to receiving care. Mississippi is the poorest state in the country and is one of five states that have only one remaining clinic.[iii] Many patients of the sole Mississippi clinic already take on the burden of cost and two to three hours of travel to receive care.[iv] The 2012 law would close the last remaining clinic in the state and would force patients to venture out of state to access care.[v] For now, the clinic remains open while the case is pending in federal court.

The distance patients must travel to reach an abortion provider negatively impacts their ability to access reproductive health services. Eighty-two percent of U.S. counties do not have abortion services and 74 percent of patients living in rural areas must travel more than 50 miles to get to the nearest abortion clinic.[vi] Rural individuals are doubly burdened by lack of access to care: not only due to a lack of providers, but also because 95 percent of U.S. counties that exhibit persistent patterns of poverty are in rural areas.[vii] In 2008, one-third of U.S. women reported travelling more than 25 miles to reach a clinic and women in states with mandatory counseling and waiting period requirements were more likely than their peers to travel even further.[viii] Despite strong evidence that medication abortion can be safely prescribed via telemedicine and dispensed by trained nurses, state legislatures have specifically targeted the way that individuals in rural areas access abortion by restricting the mode by which they receive the medicine and the medical professional who dispenses it.[ix]

Everyone deserves to make informed decisions about their health care based on scientifically accurate information from a doctor they trust, free from discrimination. Race and sex-selective abortion bans encourage medical professionals to scrutinize patients based on racial or ethnic background, based only on stereotypes.[x] Such bans do nothing to address the true causes of racism and sexism; rather, they open up the floodgates to anti-immigrant and racist sentiments based in stereotypes about the Asian American community and about a black woman's ability to determine the best course to take in her reproductive healthcare.

Furthermore, no one should not be mandated to receive or listen to false information prior to receiving care – not only because it is medically inaccurate, but also because restrictions requiring multiple visits unnecessarily increase the expense of the procedure. State-mandated biased counseling serves no purpose other than to intimidate and stigmatize patients seeking medical treatment. Such laws have been proven to drive up the cost to individuals, thereby preventing services to some patients and delaying care into the second trimester when the procedure is less safe.[xi] African American patients have been a particular target of biased counseling, based on false claims that they are targeted by abortion providers in order to commit "black genocide."[xii] Finally, our nation's youth are in special need of medically accurate information about reproductive and sexual health: for example, research shows that Asian Pacific American teens are less likely to communicate with their medical provider about sexuality and risk prevention than any other ethnic group.[xiii]

A person cannot make a meaningful decision about whether to become a parent if safe, legal, available, and affordable abortion services are out of reach. Approximately 69 percent of women

obtaining abortions live close to or below the federal poverty level and 27 percent of those women live in deep poverty, meaning that they have income at 100-199 percent of the federal poverty line.[xiv] Poor individuals who decide to have an abortion often have to wait many weeks to have the procedure while they raise the necessary funds and this wait drives up the cost and increases the risk of the procedure.[xv] Furthermore, a person working to raise the necessary funds must often divert money from paying for food, rent, or utilities, and harmful restrictions such as mandatory counseling and waiting periods compound the cost for patients due to lost wages and added childcare and transportation expenses.[xvi] Moreover, young and low-income individuals are most likely to experience such delays and thus mounting costs due to procedures performed later in pregnancy.[xvii] If a patient is ultimately unable to afford an abortion, they may be forced to carry an unwanted pregnancy to term; individuals who carry unwanted pregnancies to term are three times more likely to fall below the federal poverty line within two years.[xviii]

Our government has a particular responsibility to ensure that individuals who have limited access to affordable health care can receive the same quality of care as those with means. Due to the link between institutional racism and socioeconomic disadvantage, people of color are at higher risk of living in poverty and are more likely to lack access to regular, high-quality family planning and other health care services.[xix] People of color are disproportionately affected by restrictions that increase the cost of an abortion because they are more likely than white individuals to experience unintended pregnancy,[xx] to seek abortion care,[xxi] and to qualify for public insurance.[xxii] Sixty-six percent of women who have an abortion have some form of health insurance, but 57 percent report paying out of pocket, largely because many forms of state and federal Medicaid do not cover abortion.[xxiii] Restrictions also unduly affect immigrants, who are more likely to live in poverty than individuals born in the United States, and are routinely denied access to health care coverage, including abortion coverage.[xxiv] In fact, low-income immigrants who qualify for Medicaid are excluded from coverage for their initial five years of residence.[xxv] Undocumented individuals are unjustly excluded from federal Medicaid benefits and cannot even purchase health plans at full price in state insurance marketplaces.[xxvi] Such barriers to care are not only unfair, but are also flawed public health policy, preventing immigrants from maintaining their health and that of their families.

It should be noted that the reproductive health disparities affecting our communities are broader than high unintended pregnancy rates. More consistent exposure to medical care could improve health outcomes that significantly impact our communities, especially with regards to maternal mortality and earlier detection of cancers. Maternal mortality is highly pronounced for African American individuals, as they are three to four times more likely to die from pregnancy related causes than white patients, a risk that is compounded by lack of access to contraception.[xxvii] Lower income patients and people of color are also less likely to receive routine exams such as mammograms and pap smears that improve early detection of life-threatening conditions. Most likely due to late detection and the prohibitive cost of care, African American women are more likely than any other group of women to die from breast cancer and Latinas are more likely to be diagnosed in a later stage of cancer when it is harder to treat than are white women.[xxviii] Moreover, the racial disparity of HIV infection is stark: African American women are twenty

times more likely than white women to be infected with HIV.[xxix] One in thirty-two African American women will be diagnosed with HIV in their lifetimes.[xxx]

Taken together, the barriers to accessing safe, legal, affordable abortion care, free from medically unnecessary restriction, are formidable and seriously undermine a person's health, human rights, dignity, and self-determination. The Women's Health Protection Act would begin to address some, though not all, of these barriers, focusing on dismantling the restrictions aimed at closing clinic doors and making it more difficult and less dignified for patients to access this care. We believe that this legislation, in combination with separate, but parallel efforts to restore insurance coverage for abortion, protect abortion access for young people, and eliminate violence against providers, will return us to a landscape where everyone is able to get the health care they needs, regardless of their circumstance.

Everyone has the right to good health and well-being for themselves and their family. But for too long, the reproductive health care needs of our communities have been undermined by inaccessibility of care, prohibitive costs, discrimination, and medically unnecessary and restrictive legislation. Study after study by national and international experts show that restrictions on abortion don't reduce its frequency, but rather delay or prevent patient's access to the procedure. Everyone needs affordable and accessible pregnancy-related care, including abortion, regardless of where they lives and notwithstanding their economic or racial status or personal situation. We urge Congress to act now and pass the Women's Health Protection Act.

Sincerely,
New York Abortion Access Fund Board of Directors

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Senate Judiciary Committee Hearing Testimony
Congressional Hearing on S. 1696, the Women's Health Protection Act

July 15, 2014

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments in strong support of Senator Blumenthal's S. 1696, the "Women's Health Protection Act," which is under consideration in today's hearing before the U.S. Senate Committee on the Judiciary.

Planned Parenthood is the nation's leading women's health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the U.S. Every year, Planned Parenthood health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for sexually transmitted infections (STIs), and other essential care to nearly three million patients. As the largest sex educator in the country, Planned Parenthood provides reliable reproductive health information to a million young people and parents each year. Nearly 80 percent of Planned Parenthood patients have incomes at our below 150 percent of the poverty level and are among the most vulnerable, facing limited access to reliable and affordable health care.

Planned Parenthood Federation of America strongly supports the Women's Health Protection Act, which would create federal protections against state restrictions on abortion that do not advance women's health and safety and instead create barriers to accessing this safe and legal medical procedure. This critical legislation would protect a woman's constitutional right to access safe and legal abortion by making it unlawful for states to pass restrictions that endanger women's health and safety; interfere with women's personal medical decisions; and make it harder, and in some cases even impossible, to access safe and legal abortion. This legislation is needed to ensure that a woman's rights do not depend on her zip code.

In 2011, 36 states around the country adopted 135 new restrictions on abortion[1], making it the most harmful legislative session to women's health and safety on record. Only second to 2011's massive assault on women's reproductive rights was the legislative session in 2013, which resulted in more than 70 harmful abortion restrictions becoming law in 24 states across the country.[2] For example, South Dakota not only passed an unprecedented 72-hour mandatory waiting period in 2012, but in 2013 exempted weekends and holidays from this calculation. In 2013, Wisconsin and Alabama enacted targeted restrictions designed specifically to shut down those states' providers of safe and legal abortion. And in Texas, a plethora of new medically unnecessary abortion restrictions have already dramatically reduced women's access to abortion, especially in those parts of the state where women have the least access to health care. By September, the second largest state in the country could be left with as few as six abortion providers.

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[1] Guttmacher Institute, States Enact Record Number of Abortion Restrictions in 2011 (January 2012) Available at http://www.guttmacher.org/media/inthenews/2012/01/05/endofyear.html.

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The state laws that would be addressed by the Women's Health Protection Act are passed under the false guise of helping women. In reality, these cruel laws do nothing to advance women's health and safety but instead cut off women's access to safe and legal abortion and to the wide range of preventive services that women's health centers provide, including birth control, breast and cervical cancer screenings, and STI testing and treatment.

At Planned Parenthood, we work every day to make sure women receive the high-quality health care they need in a safe, respectful environment, including abortion. Ensuring the health and safety of Planned Parenthood patients is central to our mission, and fundamental to every person who works at Planned Parenthood. Our health centers have rigorous standards and training for staff as well as emergency plans in place because women's health is our first priority.

At the federal and state levels, there are multiple agencies that oversee and regulate Planned Parenthood and other health care providers. But we don't stop there; Planned Parenthood health centers go through an accreditation process with rigorous standards, regular review and inspections, and ongoing training. We constantly evaluate new research in the field, new recommendations from medical associations, new technologies, and feedback from patients, experts, and regulators to continue improving our practices.

We welcome oversight of all health centers and regulations that protect patient safety. But the harmful restrictions we see at the state level – such as requiring admitting privileges or that abortions be performed in ambulatory surgical centers – have no medical basis. These bills were not being advanced by or supported by medical experts but by politicians – with the end goal of making safe, legal abortion difficult or even impossible to access. Those behind these politically motivated proposals ultimately hope to shut down our health centers, which would leave thousands without care.

For example, there is no medical basis for laws requiring doctors who provide abortion to have admitting privileges. Data, including from the CDC, shows that abortion has over a 99% safety record.[3] The American College of Obstetricians and Gynecologists and the American Medical Association both oppose these restrictions.[4] For patients' safety, providers already have plans in place in the exceedingly rare case of emergency. The state of Alabama's own Department of Health said an admitting privileges law was not necessary and urged the state not to pass it.[5] An independent, court-appointed medical expert in the Wisconsin admitting privileges trial said to the judge, "I think it is an unacceptable experiment to see if you decrease access (to abortion) and see if more women die. It is not acceptable. It is not ethical. People will resort to illegal abortions."[6] And the Oklahoma State Medical Association (OSMA) spoke out against admitting privileges legislation there, writing that it: "would result in the Legislature and unelected bureaucrats at the

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[3] Pazol, Karen, et al. (2013). "Abortion Surveillance — United States, 2010." *MMWR*, 62(ss08);1-44. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6208a1.htm?s_cid=ss6208a1_w

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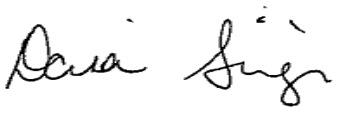
[6] Van Egeren, Jessica. "Court's impartial doctor: Decreasing access to abortion clinics an 'unacceptable experiment." The Cap Times, 29 May 2014. Available at http://host.madison.com/news/local/writers/jessica_vanegeren/court-s-impartial-doctor-decreasing-access-to-abortion-clinics-an/article_9d1da286-e768-11e3-973e-001a4bcf887a.html

Department of Health interfering in the physician/patient relationship and crafting more burdensome regulations that... may not reflect medical science or the best interest of the patient."[7]

The United States continues to have some of the highest rates of teen pregnancy and maternal and infant mortality rates in the developed world. There are significant gains to be made in protecting women's access to comprehensive health care. We need federal policy - like the Women's Health Protection Act - that will put women's rights, health, and lives first by stopping harmful state restrictions from interfering with women's personal decision-making and constitutionally protected rights, and ultimately their ability to access comprehensive preventive health care services.

Sincerely,



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[7] OSMA Opposition to SB 1848." Letter to Oklahoma State Senate. 14 Feb. 2014

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July 15, 2014

The Honorable Patrick Leahy
437 Russell Senate Office Building
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The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Leahy and Ranking Member Grassley:

Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. A large number of the doctors Physicians represents practice in the field of obstetrics and gynecology, but many are pediatricians, family physicians, cardiologists, neurologists, radiologists, and others. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients.

Physicians welcomes the opportunity to submit testimony on the Women's Health Protection Act of 2014 (S. 1696). This critical bill would ensure that all women are able to make personal decisions about reproductive health care, regardless of where they live.

I. Introduction

As physicians, patient safety is our top priority. Which is why we are dismayed by the actions of politicians across the country who have passed harmful restrictions on abortion in the name of patient safety. In many states, the effect has been catastrophic, as politicians have increasingly sought new ways to interfere with the patient-provider relationship and undermine women's access to safe abortion care.

Abortion is one of the safest medical procedures in the United States. Rates of infection and serious complications following a medication or surgical abortion are extremely low. In fact, data from the Centers for Disease Control and Prevention (CDC) found that abortion has over a 99% safety record.[1] State lawmakers are actually harming women by decreasing access to safe and legal abortion care.

[1] Karen Pazol et al., Centers for Disease Control and Prevention, *Abortion Surveillance – United States, 2009*, Morbidity and Mortality Weekly Report 61:1-44, Table 25 (Nov. 23, 2012), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6108a1.htm (last visited July 10, 2014).

As physicians, we provide the highest quality, most compassionate, safest medical care, and in some states now, we are unable to because of unnecessary laws. Allow me to give you some examples from our members of restrictive state laws that are hurting our ability to practice medicine and jeopardizing our patients' health and lives.

I. Laws mandating unnecessary visits to a clinic

Several states require unnecessary in person visits for women seeking abortion care. Missouri has a mandated 24-hour waiting period for women having abortions. Dr. Elizabeth Schmidt practices in Missouri and recently had a patient, Sonia[2], who was pregnant with a fourth child. She and her husband were initially ecstatic about the pregnancy until she was diagnosed with an aggressive form of breast cancer. She needed to terminate the pregnancy immediately to start chemotherapy. Due to a mandatory waiting period, she was forced to wait 24 hours before Dr. Schmidt could perform her abortion. It is cruel that Missouri state law forced Sonia to wait to start life-saving treatment.

Dr. Colleen McNicholas also practices in Missouri and cared for a patient named Julie. She and her husband were told early in her pregnancy that the much desired baby they were expecting was affected with multiple abnormalities, the sum of which would not allow their baby to survive outside the womb. Sadly, Julie and her husband were given no assistance when they requested information on pregnancy termination. They were heartbroken, both by the diagnosis and what they perceived was a lack of compassion by their physician. Without the help of their primary obstetrician, they attempted to navigate the complicated environment around pregnancy termination in Missouri. It took them 3 weeks to locate an abortion provider, only to be told that there would be additional delays. Under Missouri's restrictive laws, Julie would be required to travel two hours to a facility on two separate occasions to comply with the state required 24 hour waiting period. When they were able to finally access the care they deserved, Julie's pregnancy was a little over 20 weeks pregnant. Julie's story of unnecessary delays and onerous requirements is unfortunately not uncommon, especially in places where access to providers is so limited.

Just this year, the Missouri legislature voted to extend the waiting period to three days. While the governor vetoed this harmful legislation the legislature will likely try to enact it again, increasing the burdens on Missouri women like Sonia and Julie.

II. Hospital admitting privilege requirements

As physicians, we oppose legislative interference in the practice of medicine, including requiring admitting privileges, as they do nothing to protect the health of our patients and are contrary to modern medical practice. Surgical abortion is associated with similar or fewer risks compared to other outpatient surgical procedures, yet states with such restrictions only require providers of abortion care to have admitting privileges. For example, the mortality rate of colonoscopy is more than 40 times greater than that of abortion, and yet, no state has imposed admitting privilege requirements for gastroenterologists who

[2] All patient names have been changed to protect confidentiality.

perform these procedures.[3] There is simply no medical reason to treat abortion providers differently from other providers of procedures with similar or greater risks of complications. That abortion is singled out shows that the true motivation of these laws it to limit access.

Requiring abortion providers to have hospital admitting privileges jeopardizes women's access to safe and legal abortion care by preventing qualified health centers and providers from offering abortion care, forcing many to shut down. After a Texas law requiring hospital admitting went into effect in November of 2013, 19 of 33 abortion clinics closed, including clinics in McAllen and Beaumont. The closure of the McAllen clinic, located in the Rio Grande Valley (one of the poorest regions in the nation), has forced women to make an estimated two-and-a-half hour (150 mile) drive to Corpus Christi, four hour (240 mile) trip to San Antonio, or five hour (310 mile) drive to Austin.[4] These distances can prove to be insurmountable obstacles for low-income women, leading some to seek more accessible but illegal abortion pills from Mexico or forcing them to have and raise a baby they feel unprepared for.[5] Neither of these scenarios is good for women's health or dignity.

III. Unnecessary regulations that single out abortion

Many states have laws and regulations in place that are not related to improving patient outcomes. Regulations governing abortion practice should be rooted in evidence-based medicine, serve legitimate health interests, and not impede access to abortion care. Numerous states single out abortion providers for regulation not required of other outpatient facilities providing similarly complex medical services. These measures serve only to impair access to abortion which is not beneficial to women's health. On September 1, 2014, when a Texas provision requiring clinics to conform to ambulatory surgical center standards goes into effect, it is estimated that many additional clinics will close, leaving only six clinics in the state of Texas, the second most populous state in the country.

Lack of access to abortion care has a great impact on patients. Dr. Leah Torres practices in Utah and cared for a patient, Jenny, who drove several hours from home in order to get her abortion. She had four children and was struggling to get by. Once she saved the money for the procedure, she realized there were no local doctors who could take care of her. Her own physician told her that if it were not for unnecessary regulations requiring his clinic to conform to ambulatory surgical center requirements, he could have provided the care. However, only one clinic in the state met these requirements and that was five hours away. But under Utah state law, Jenny still had to wait 72 hours and then find child care and take time off of work to make the long trip. When she finally saw Dr. Torres, Jenny was exasperated and distraught, especially because of the barriers she faced to receive care. She was confident in her decision to have her

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[3] Brief of *Amici Curiae* American College of Obstetricians & Gynecologists and the American Medical Association in support of Plaintiffs-Appellees at 4, fn. 10, Planned Parenthood of Greater Texas Surgical Health Services v. Attorney General Gregory Abbott, No. 13-51008 (5th Cir. Dec. 19, 2013).

[4] Manny Fernandez, *Abortion Law Pushes Texas Clinics to Close Doors*, THE NEW YORK TIMES, (March 6, 2014), http://www.nytimes.com/2014/03/07/us/citing-new-texas-rules-abortion-provider-is-shutting-last-clinics-in-2-regions.html?_r=0.

[5] Rick Jervis, *Texas abortion law creates obstacles for Valley women,* USA TODAY, (May 17, 2014), http://www.usatoday.com/story/news/nation/2014/05/17/texas-abortion-law-women-valley/8804871/.

abortion. She only regretted living in a place where she could not obtain this safe and legal procedure sooner. While abortion is very safe, risks increase when women are forced to delay obtaining care.

IV. Measures limiting the provision of medication abortion

There are two ways to end a pregnancy in the first trimester – a brief surgical procedure or a regimen of two medications. Each year, roughly 200,000 U.S. women use medications to end a pregnancy. The most widely used medication is mifepristone (available in the United States as Mifeprex and also known as RU-486) along with misoprostol. Mifepristone was approved for use by the U.S. Food and Drug Administration (FDA) in 2000.

Numerous studies confirm that mifepristone is equally effective at lower dosages than the regimen in the 2000 FDA label, meaning that a woman can take one pill as opposed to three pills, which causes fewer side effects and decreases costs. Studies also show that a woman can follow directions and take the second medication at home instead of returning to the clinic or doctor's office to be handed a pill. Lastly, researchers have found that mifepristone is safe and effective in the first ten weeks of pregnancy, expanding safe access to this method past the original 7 weeks in the FDA label.

Study after study has established that these regimens are safe, more effective, and carry fewer side effects. These evidence-based regimens have become standard medical practice in the U.S. and abroad.[6] But that has not stopped state legislatures from trying to limit clinicians to the outdated FDA regimen and thus limit women's access to this early, safe option.

Dr. Lin-Fan Wang, who works in New York City, cared for Mary, a 35-year-old elementary school teacher with a 10-year-old son, who she sees every year for her physical. At her recent physical, Mary told Dr. Wang that she thought she was pregnant, which her pregnancy test confirmed. She immediately became tearful and said that she could not continue the pregnancy – she was already having a hard time juggling a full time job and raising her son as a single mom. They discussed her options, and she decided to have a medication abortion. Because Mary lives in New York, that same day, Dr. Wang gave her the first pill, and Mary was able to take the second set of pills and complete the abortion in the privacy and safety of her own home. At Mary's follow-up visit, she said that she was so grateful that her doctor was able to provide her abortion on the same day as her clinic visit. The care that Mary received is the high quality, evidence-based care we strive to deliver as health care professionals.

In contrast, Ohio, where Dr. Lisa Perriera practices, is one such state that mandates the use of outdated protocols. A woman in Ohio must make four visits to the clinic and take the second medication in the clinic or doctor's office rather than in the comfort of her home. For women able to access medication abortion,

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[6] ACOG practice bulletin on medical abortion, "Medical Management of First-Trimester Abortion," #143, March 2014, http://www.acog.org/~/media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb143.pdf?dmc=1&ts=20140703T1932230602).

this protocol subjects them to higher risk of side effects, and for patients that travel to Ohio from Kentucky or West Virginia, some of these women can begin to pass the pregnancy in the car on the drive home. This Ohio law does nothing to make abortion safer—all it does is limit access to safe medication abortion. These restrictive laws effectively remove medication abortion as an option for many women by making it more expensive and requiring four trips to the clinic. This is detrimental to women's health. For some women, using medications to end a pregnancy is preferable. For example, medication abortion may be medically indicated for women who have certain uterine anomalies, have large uterine fibroids, or are extremely obese. In what other area of medicine, is a safe alternative treatment effectively banned?

V. Bans on second-trimester abortion care

Although most abortions in the United States are provided early in pregnancy, some women will need abortion care later in pregnancy. Many serious health conditions materialize or worsen in the second trimester and compromise the health of a pregnant woman. State lawmakers have been relentless in passing abortion bans that are clearly unconstitutional, often contain only narrow and inadequate health exceptions, and deny our patients crucial medical care.

Physicians for Reproductive Health's consulting medical director, Dr. Anne Davis of New York, cared for Brenda, a mother of two who was 22 weeks pregnant. She had been bleeding throughout her pregnancy, but since this was a very desired pregnancy, she was waiting and hoping for the best. Her condition developed into placental abruption; the placenta had separated from the uterine wall, causing potentially life-threatening bleeding. Her bleeding worsened and she was reaching the point where she would have suffered massive hemorrhage, shock, and death. Her pregnancy was dangerous to her and had to end. Because she lived in New York, Dr. Davis was able to provide the abortion care she needed quickly and safely. Brenda survived and hopes to have more children.

One of my patients, Jane, and her husband were expecting their first child. But her ultrasound at 20 weeks revealed that fetus had a significant cardiac abnormally. After consulting with specialists and having additional tests, they found out that the diagnosis was a lethal genetic anomaly, Trisomy 18. The majority of pregnancies diagnosed with Trisomy 18 result in stillbirths and most babies born with this genetic condition do not live more than a few days. Jane and her husband decided to terminate the pregnancy. Fortunately, in my state Jane and her husband had time for the necessary testing, consultation, counseling and reflection.

Bans on abortion care in the second trimester jeopardize the lives and health of our patients. Lethal fetal abnormalities are often not diagnosed until after 20 weeks and medical complications in pregnancy that endanger women's health can present during this time as well. These bills force women to travel greater distances for abortion care or deny them safe care altogether. Women and families need compassion and the ability to make decisions with dignity, not arbitrary barrier that limit their access to safe care.

VI. Conclusion

As physicians, we are obligated by professional ethics to provide the best care possible to our patients. Why would we give more medication than necessary? Or require a woman to make an unnecessary trip to see a doctor when she does not need to? Why should a state single out abortion for needless regulations not imposed on other health care providers? These medically unjustified laws replace medical judgment with

political agendas. These intrusions into the practice of medicine are offensive to doctors and the women for whom they care, and ominously threaten medical and scientific integrity.

The care Mary received in New York from Dr. Wang was based on the best available medical evidence. The care that the women in Missouri, Ohio, and Utah received was based on legislators dictating medical practice, harming their female constituents. It is unjust that accessible abortion care is dependent on a woman's zip code.

Every woman has her own unique circumstances and must be able to make personal medical decisions, including the decision to have an abortion, without political interference. For these real women and their families, the decision to have an abortion was made after consultation with their health care providers and consideration of all the issues involved. Abortion was a critical medical procedure that protected their health as well as the well-being of their families.

As physicians, we work every day to make sure our patients receive the high-quality health care they need in a safe, respectful environment. We need the Women's Health Protection Act to ensure that all women have access to comprehensive reproductive health care, including abortion, regardless of where they live. It is critical to the lives and health of our patients that this bill passes. For these reasons, I ask you to please support S. 1696.

Sincerely,

Dr. Nancy Stanwood, MD, MPH
Board Chair, Physicians for Reproductive Health

United States Senate

Committee on the Judiciary

Hearing on S.1696

Women's Health Protection Act

Tammi Kromenaker

Clinic Director, Red River Women's Clinic

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

Red River Women's Clinic respectfully submits the following testimony in support of S.1696 (the Women's Health Protection Act) to the United States Senate Committee on the Judiciary.

I. Red River Women's Clinic and Its Patients

My name is Tammi Kromenaker and I am the Director of Red River Women's Clinic. I have been working in the field of reproductive health care for more than 20 years, and have dedicated my career to providing safe, effective, and compassionate reproductive health care to the women of North Dakota and the surrounding states. Red River Women's Clinic is the only abortion provider in the state of North Dakota and has provided safe abortion care and other reproductive health care services to women in North Dakota for 15 years. We maintain the highest quality standards for our practice. Red River Women's Clinic mission is to not only provide safe reproductive health services, but to also provide those services in an emotionally supportive environment.

Red River Women's Clinic provides abortion and other reproductive health care services to women from a broad range of backgrounds. Approximately 60% of our patients are already mothers, with at least one child at home. These women rely on their own personal experiences and understanding of pregnancy and parenting to make careful, considered decisions about what is best for themselves and their families. Some patients seek abortion because they are pregnant as a result of rape, are victims of domestic violence, or because the pregnancy poses a risk their health. In addition, most of our patients get abortions very early in pregnancy – 92% of all abortions performed at our clinic are in the first trimester. Many women from all different backgrounds have sought services at the clinic at some point in their lives.

For my patients who are already parents, who are low-income, or who just cannot raise a child at this point in their lives, accessing safe, legal abortion care is essential for them to be able shape their destiny and the future of their families. When women choose for themselves when they are ready to provide for a child, the entire family and society benefit. Having control over whether and when to become a parent means more opportunities for education, employment, and adequate health care for women and families. It means their children will get the love and attention that is essential for healthy development. Choosing abortion care can be one of the most empowering life choices a woman makes. It may mean that she can leave an abusive relationship, continue to care for the children she already has, take back control after a sexual assault, or continue treatment for a chronic illness.

The clinic serves women who reside in the state as well as women who travel from South Dakota and Minnesota, and on occasion, from as far away as Canada. Currently, approximately two-thirds of the clinic's patients travel to the clinic from at least an hour away, and almost half of all patients travel for more than two hours. On average, our patients drive approximately 120

miles (240 miles round-trip) in order to reach Red River Women's Clinic. Some patients have told me that making the trip to our clinic was difficult for them because of the distance, or because of their financial situation. In addition, some of our patients have confided in me that they were in abusive relationships and that this situation made it very difficult to get away from home in order to be seen at the clinic. As the last remaining option for women in North Dakota and the surrounding area seeking a safe and legal abortion, it is difficult for me to see my patients struggle financially and logistically to access care that is critical to their health and well-being, and protected by the Constitution.

II. Legislative Attacks on Abortion Care in Recent Years

I support reasonable, evidence-based regulations for all forms health care—including abortion care—that truly promote patient health. All three of the physicians who work at Red River Women's Clinic are board-certified and licensed to practice medicine in North Dakota, and we comply with myriad laws and rules that apply to the provision of health care, just like any other medical profession. However, North Dakota currently has numerous laws restricting abortion on the books that have no bearing on patients' health and safety. And in recent years the North Dakota legislature doubled down on their hostility to abortion access, passing six new bills restricting access to abortion *in the last two legislative sessions alone*,[1] including the most extreme, and blatantly unconstitutional, abortion ban in the nation—at 6 weeks of pregnancy.[2] These bills also included a restriction on medication abortion that would have effectively banned

[1] H.B. 1297, 62d Leg. (N.D. 2011); codified at N.D. CENT. CODE § 14-02.1-03.5; H.B. 1305, 63rd Leg. (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-04.1; H.B. 1456, 63rd Leg. (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-05.2; S.B. 2368, 63rd Leg. (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-05.3; S.B. 2305, 63rd Leg (N.D. 2013), codified at N.D. CENT. CODE § 14-02.1-04(1); S.R. 4009, 63rd Leg. (N.D. 2013).
[2] N.D. CENT. CODE § 14-02.1-05.2 (2013).

it entirely[3] and requiring physicians who perform abortions to have admitting privileges at a local hospital,[4] which is completely unnecessary to ensure women's health or safety. These requirements shamelessly single out Red River Women's Clinic, the last remaining option for women in North Dakota to access safe and legal abortion services, and treat us differently than other medical providers that perform similar services.

We have gone to court to fight nearly every one of these harmful measures enacted since 2011, and we have won injunctions against several of them.[5] But North Dakota women—and the health care providers who serve them—should not have to file lawsuits year after year, fighting restriction after restriction, to protect their basic constitutional rights. This laser-focus on eviscerating the right to abortion has created a situation in which North Dakota women have different constitutional rights than women in other parts of the country: Women in California or New York do not have to go into court year after year to keep their reproductive health centers' doors open. It's time for Congress to step in.

III. A National Response is Needed: The Women's Health Protection Act

In signing the nation's most extreme abortion ban last year, North Dakota Governor Jack Dalrymple said: "Although the likelihood of this measure surviving a court challenge remains in question, this bill is nevertheless a legitimate attempt by a state legislature to discover the boundaries of Roe v. Wade," calling the "constitutionality of [the] measure" an "open

[3] N.D. CENT. CODE § 14-02.1-03.5 (2011).
[4] N.D. CENT. CODE § 14-02.1-04(1) (2013).
[5] *MKB Management Corp. v. Burdick*, No. 09-2011-CV-02205 (N.D. Dist. Ct., Cass Cnty. July 15, 2013) (order granting permanent injunction); *MKB Management Corp. v. Burdick*, No. 09-2011-CV-02205 (N.D. Dist. Ct., Cass Cnty. July 31, 2013) (order granting preliminary injunction), *dismissed without prejudice*, No. 09-2011-CV-02205 (N.D. Dist. Ct. Mar. 14, 2014); *MKB Management Corp. v. Burdick*, --- F. Supp. 2d ---, 2014 WL 1653201 (D.N.D. Apr. 16, 2014) (order granting permanent injunction).

question."[6] But women's fundamental constitutional rights aren't subject to experimentation, state by state. This outrageous statement underscores the fact that the women I serve simply cannot rely on their state elected officials to respect and protect their constitutional rights. They need federal protection—they need the Women's Health Protection Act.

The Women's Health Protection Act would create federal protections against exactly the relentless attacks on women's health enacted by the North Dakota legislature in recent years—laws that single out health care providers like Red River Women's Clinic and do not apply to other, similar health care providers, with the goal of blocking access to safe and legal abortion care. The Women's Health Protection Act would prohibit states from passing the extremely dangerous types of measures Red River Women's Clinic is currently fighting in court, like the near-total abortion ban and the admitting privileges law that was designed to close our clinic. The Women's Health Protection Act would also protect North Dakota women against harmful abortion restrictions that do nothing to advance women's health and safety, which our state legislature seems bent on passing, year after year.

Our constitutional system was not set up so that a woman's fundamental constitutional rights depend entirely on where she lives. North Dakota women need and deserve access to safe and legal abortion care, without political interference, and without running to court each and every time the legislature threatens to choke off that access. Passing the Women's Health Protection Act would take the critical step of ensuring that the individual constitutional rights of every woman would be protected as a matter of federal law, whether she lives in Bismarck or Boston.

[6] Governor Provides Statement on Signed Bills, North Dakota Office of the Governor (Mar. 26, 2013), *available at* http://governor.nd.gov/media-center/news/governor-provides-statement-signed-bills.

Reproductive Health Technologies Project

Women's Health Protection Act (S 1696)
Testimony Presented by Jessica Arons, President & CEO
U.S. Senate Committee on the Judiciary
July 15, 2014

To Chairman Leahy, Ranking Member Grassley and members of the Committee: I am honored to submit this testimony. Today you are considering the Women's Health Protection Act (S.1696), introduced by Sen. Richard Blumenthal (D-CT).

The mission of the Reproductive Health Technologies Project (RHTP) is to advance the ability of every woman of any age to achieve full reproductive freedom with access to the safest, most effective, appropriate, and acceptable technologies for ensuring her own health and controlling her fertility. To fulfill this mission, RHTP seeks to build consensus in support of an education, research and advocacy agenda for reproductive health and reproductive freedom.

RHTP was founded in order to bring mifepristone to the U.S. market as a non-surgical abortion option. We feel that it is our unique mission and responsibility to ensure that medication abortion remains a meaningful and viable option for women seeking to end a pregnancy, especially as the availability of surgical abortion continues to decline across the country. Moreover, it is one of our highest priorities to eliminate the cost barriers to abortion care in this country.

Medication Abortion Restrictions

Mifeprex (the brand name of mifepristone) was approved by the U.S. Food and Drug Administration (FDA) in September 2000 as a pharmaceutical method for early abortion. Over the last 13 years, women have welcomed the abortion pill as a less clinical, more private, non-invasive option for early-term abortion.

Abortion opponents have pursued a number of strategies in various states to limit women's access to this safe and effective way to end a pregnancy in the first trimester. On the surface, the restrictions may seem reasonable. But upon further examination, it becomes clear that these laws single out abortion care and treat it differently than other types of health care in ways that could be detrimental to women's health.

When a woman needs to end her pregnancy, it is important that she have access to safe medical care from a range of qualified medical professionals who are able to practice medicine in compliance with the most up-to-date standards of care. Unfortunately, many state legislatures, driven by anti-abortion ideology instead of informed by science, have imposed restrictions on medication abortion that do not improve health or safety outcomes for women.

Physician-Only Requirements:
Thirty-eight states require that medication abortion must be administered by a licensed physician.[1]

[1] Guttmacher Institute, *State Policies in Brief: Medication Abortion* (July 1, 2014), available at http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf.

- There is no medical necessity for mifepristone to be provided solely by a doctor rather than other types of licensed medical personnel, such as physicians' assistants or nurse practitioners.[2]
- As with most restrictions on abortion, this limitation is not about patient safety and does not improve patient care.
- The result of physician-only restrictions is to make it more difficult, and often more expensive, to provide medication abortion to a woman who seeks this option.

Telemedicine Restrictions:

- Fifteen states currently require the clinician providing a medication abortion to be physically present during the procedure, which effectively prohibits the use of telemedicine (such as video conferencing) to prescribe medication remotely.[3]
- In places where mifepristone is administered remotely by a physician after consultation via video, patients report a high level of satisfaction and studies have shown it to be a safe and effective practice for the provision of abortion care.[4]
- Mifepristone is the only drug that has been explicitly limited in its telemedicine use, while access to a range of other healthcare options via such methods is rapidly expanding.[5]
- Given continued technological advances and the potential to meet the healthcare needs of underserved populations, telemedicine should be encouraged as a way to meet women's reproductive health needs into the future rather than added to the list of ways women are denied abortion care.

Prohibitions on Off-Label Use:

Ohio and Texas currently require mifepristone to be administered in compliance with the FDA protocols stated on the drug's label, rather than based on the current evidence-based standard that has been developed in clinical practice (considered "off-label" use). Oklahoma also passed a law prohibiting off-label use of mifepristone that will become effective later in 2014.[6]

- Strict compliance with FDA labeling protocol for mifepristone requires: administering a higher dose than is necessary (600 vs. 200 mg), which also makes the procedure more expensive; using the drug only during the first seven weeks of pregnancy, as opposed to nine weeks in the off-label regimen; and having a woman complete her abortion procedure in a clinic instead of at home.

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[2] J. Yarnall et al., "Non-Physician Clinicians Can Safely Provide First Trimester Medical Abortion," *Reproductive Health Matters* 17(33): 61-9 (May 2009); American Public Health Association, *Policy Statement: Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants* (November 2011).

[3] Guttmacher Institute, *Medication Abortion.* States with current bans are AL, AZ, IN, KS, LA, MI, MO, MS, NC, NE, OK, SD, TN, and TX. In addition, the IA Board of Medicine passed an administrative rule in 2013 to ban the use of telemedicine for abortion, which has been temporarily enjoined by court order.

[4] D. Grossman et al., "Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine," *Obstetrics & Gynecology* 118 (2 Pt. 1): 296-303 (August 2011).

[5] Reproductive Health Technologies Project, "Telemedicine and the Potential for Expanded Access to Reproductive Health Care" (June 2014), available at http://www.rhtp.org/contraception/documents/TelemedicineandReproductiveHealthJune2014FINAL.pdf; American Telemedicine Association, "Telemedicine Case Studies," available at http://www.americantelemed.org/about-telemedicine/telemedicine-case-studies.

[6] Guttmacher Institute, *Medication Abortion.* AZ and ND also enacted similar statutes, which have been enjoined by court order. TX allows a lower dose of mifepristone to be used, in line with the evidence-based protocol, but providers must adhere to the rest of the outdated FDA labeling requirements.

- It is common medical practice to rely on "off-label" use of medication. According to the American Medical Association, approximately 20% of all prescriptions are written off-label; the range is 50-75% for pediatric uses, as children are rarely included in clinical drug trials.[7]
- Most physicians prefer the "off-label" regimen for Mifeprex because it is safe and effective and has improved patient care. The American College of Obstetricians and Gynecologists (ACOG) recommends the lower-dose mifepristone regimen in its guidelines for physicians, citing fewer side effects and lower cost for patients.[8] Today, 96% of all medication abortions in the U.S. depart from the original FDA protocol.[9]

Barriers to Abortion Access

Current state restrictions on abortion access burden women seeking both surgical and non-surgical abortion care. The average cost of a medication abortion in a clinic is $504 and a first-trimester surgical abortion is $480.[10] While this amount may seem nominal to a U.S. Senator, it can mean the difference between getting necessary medical care to end a pregnancy and paying for rent, food, or utilities to a woman living on the brink of poverty. And due to draconian laws like the Hyde Amendment, which denies Medicaid coverage for abortion care in most circumstances, poor women typically must find a way to pay for an abortion procedure entirely out of pocket.

There have been 205 restrictions related to abortion services passed by state legislatures from 2011 through 2013.[11] Most popular among this recent spate of legislative activity are Targeted Regulations of Abortion Providers (TRAP) laws. Passed under the pretense of making abortion safer for women, these measures involve the imposition of unnecessary, arbitrary, and burdensome standards that have led to a number of clinics shutting down because they cannot afford to make the required costly renovations. Despite the lip service given to women's health and safety by these bills' proponents, the real purpose of these measures is to put abortion clinics out of business.[12]

The most marginalized people – poor women, rural women, young women, women of color, and immigrant women – bear the greatest burden of such restrictions. For instance, women in the Rio Grande Valley in Texas have seen the only two abortion clinics in the region close their doors as a result of the state's TRAP laws, leaving them without access to a provider within 240 miles.[13] This area, where

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[7] American Medical Association, National Task Force on CME Provider/Industry Collaboration, "On-Label and Off-label Usage of Prescription Medicines and Devices, and the Relationship to CME" (2010), available at http://www.ama-assn.org/ama1/pub/upload/mm/455/fact-sheet-4.pdf.

[8] ACOG Practice Bulletin no. 67, "Medical Management of Abortion" (2009).

[9] Brief in opposition for Oklahoma Coalition for Reproductive Justice, *Cline v. Oklahoma Coalition for Reproductive Justice,* U.S. Supreme Court, no. 12-1094, May 2013.

[10] J. Jerman and R. Jones, "Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment," *Women's Health Issues* 24-4: e419-24(May 2014).

[11] H. Boonstra and E. Nash, "A Surge of State Abortion Restrictions Puts Providers – and the Women They Serve – in the Crosshairs," *Guttmacher Policy Review* 17(1) (Winter 2014), available at http://www.guttmacher.org/pubs/gpr/17/1/gpr170109.html.

[12] For example, see comments by Mississippi Governor Phil Bryant on a 2012 state law requiring hospital admitting privileges for providers at the state's only abortion clinic: "My goal of course is to shut it down." Ross Adams, "Deadline Day for Jackson Abortion Clinic," WJTV.com, January 10, 2013, available at http://www.wjtv.com/story/21270984/deadline-day-for-jackson-abortion-clinic.

[13] Manny Fernandez, "Abortion Law Pushes Texas Clinics to Close Doors," *New York Times,* March 6, 2014, available at http://www.nytimes.com/2014/03/07/us/citing-new-texas-rules-abortion-provider-is-shutting-last-clinics-in-2-regions.html.

more than 30 percent of people live under the federal poverty level, is home to the largest concentration of low-wage farmworkers in the country.[14] Already cut off from health care generally (in part because of Texas's concomitant defunding of family planning clinics[15]) and already experiencing some of the largest health disparities in the country, these women are now facing a public health crisis of monumental proportions.[16]

With fewer clinics, the additional costs involved in obtaining an abortion increase as well – in transportation, lodging, time off work (often unpaid), and child care.[17] TRAP laws, especially in combination with abortion funding and coverage bans like the Hyde Amendment, are making abortion care unaffordable for the women who need it. Just as poll taxes made voting unaffordable for African Americans, so too is this toxic combination of abortion restrictions putting abortion care out of reach for the women in this country who are already struggling to get by.

How the Women's Health Protection Act Would Address These Restrictions

RHTP has worked for over twenty years to ensure that a full range of effective reproductive health care options are available to all women. We vociferously oppose the onerous and unnecessarily restrictive state laws detailed above that have absolutely no medical basis and may even threaten women's health and safety. The Women's Health Protection Act (WHPA) would establish a national baseline of protections for women's access to reproductive health care around the country, rather than allowing them to be subjected to a patchwork quilt of increasing restrictions in various states.

WHPA's provision to bar states from imposing medically unnecessary regulations solely on reproductive health care providers would reduce restrictions on both surgical and non-surgical abortion procedures. In the provision of medication abortion, for example, states would not be allowed to dictate that abortion providers adhere to the outdated FDA protocol in prescribing Mifeprex, a type of regulation that does not apply to any other area of medical practice. Indeed, it would be unheard of to disallow a safe and widely used evidence-based "off label" approach in any other medical setting.

We applaud Sen. Blumenthal for introducing WHPA and its congressional intent to expand access to clinical abortion care. We would also welcome legislative efforts to remove abortion restrictions that target low-income women, young women, and those who need later abortion care. In sum, we urge your support for WHPA so that women can access safe, quality, affordable abortion care no matter where in the U.S. they live.

[14] Center for Reproductive Rights & National Latina Institute for Reproductive Health, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley* (November 2013).
[15] K. White et al., "Cutting Family Planning in Texas," *New England Journal of Medicine* 367: 1179-81 (September 2012).
[16] Center for Reproductive Rights & National Latina Institute for Reproductive Health, *Nuestro Texas*.
[17] L. Finer et al., "Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States, *Contraception* 74(4):334–344 (April 2006).

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July 14, 2014

Senator Richard Blumenthal
U.S. Senate
724 Hart Senate Office Building
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Dear Senator Richard Blumenthal:

I am writing to lend my unwavering support for your legislation, the Women's Health Protection Act, S.1696. Thank you for having the courage to introduce S. 1969 – and for attempting to roll back the onslaught of laws now sweeping the nation that claim to protect women's health but in actuality make it harder to get safe, legal abortion care.

Five years ago today, I terminated my much wanted and loved pregnancy. It was the most gut-wrenching, impossibly difficult act. It is also one that I am profoundly grateful I could choose, and have performed safely.

Despite being legal, my experience was filled with undue hardship. And my abortion took place **before** many of the laws (active and proposed) sweeping across our country took hold.

My diagnosis:

In July 2009, at nearly 31 weeks into my pregnancy, my husband and I received shocking and devastating news about the health of our unborn daughter. After nearly 8 months of prenatal care that indicated the pregnancy was progressing along perfectly normal, we learned our baby was missing a main piece of her brain…the part that connects the right and left hemispheres. This is known as agenesis of the corpus callosum. Additionally, the surface of the brain was malformed and severely underdeveloped, a condition called polymicrogyria. Where brain mass and tissue should have grown and been plentiful, only large pockets of empty space and gaping holes existed.

Because of the severe brain anomalies, our baby would have had on-going seizures -- 70% of the time. And that was best case scenario. Our daughter would lack the physical coordination to suck, swallow, feed, walk, talk or know her environment -- if she survived birth at all.

If we had carried our baby to term, we would have needed a resuscitation order in place prior to giving birth as she was incapable of living without significant medical assistance.

And no amount of surgery, medicine or physical therapy could reverse, improve, or fix this horrendous diagnosis.

We did not want our daughter to exist solely because of machines where she would never run, laugh, play or interact with me, her mommy or her daddy or her big brother Nate or her dog Misty. We did not want to bring a child into this world that would only be here in a vegetated state, if at all.

As much as we loved and wanted our daughter, we didn't want her existence to be one of constant suffering.

Forced to travel out of state for care:

Because I was so far along in my pregnancy, and it was 6 weeks after Dr. Tiller had been murdered, the only option available at the time of our diagnosis was for me to travel across the country from Maryland to Colorado to one of a handful of facilities in the U.S. that provides later abortion care.

I was completely unprepared for this logistical obstacle because I knew abortion care was legal in Maryland. But with no practicing physician to help in the summer of 2009, my only option was to travel out of state.

It was awful to go through the hell of ending my very much wanted and loved pregnancy and to have to do it across the country, so far from my home and loved ones.

Implications of proposed nation-wide 20 week ban:

It never occurred to me that a fetal anomaly would exist in our baby – and that it would go undetected despite the prenatal care I received until so late in my pregnancy. There was nothing in our family history that put us at an elevated risk for a genetic abnormality and all the testing due to my "advanced maternal age" of 38 returned normal.

I quickly learned that a diagnosis like mine couldn't have occurred and was impossible to confirm until much, much later than 20 weeks because brain development happens well into the third trimester.

Although my termination came later in pregnancy than most, if nothing is done to stop 20-week ban legislation, had I been subjected to the legislation, I would have been forced either to seek an illegal procedure, to leave the country, or to carry a doomed pregnancy to term, risking my health and enduring warm "congratulations" from everyone on the street, which is a fate that is beyond cruel for women caring a fetus that is incompatible with life.

The period of time I had to endure between learning our diagnosis and ending her suffering was agonizing. Each movement of my baby – movement that for months had brought me such joy – now brought only unbearable heartache.

Looking down at my full pregnant belly knowing how sick my daughter was, and knowing that she would not live was horrendous.

I am extremely fortunate to have given birth to two healthy children since our loss. During both of those pregnancies, it wasn't possible to begin to test for what was wrong with our first daughter until the 20 week mark at the earliest. And had either pregnancies shown signs of brain malformation at that time, only the agenesis of the corpus callosum would have appeared – not the other, more severe abnormalities as it would have been too early based on brain development and gestational age.

If we do nothing to stop the 20-week bans from passing in states across the country, not only would the anomalies we experience not be identifiable in time, but even if we could spot something immediately prior to or just at the 20 week mark, there wouldn't be time to monitor and confirm the severity of the problems. No mother or her family should be forced to rush testing, consultation and decision-making about something as serious as the viability of their baby because of an abortion time limit.

Forced ultrasound technology:

Ultrasound technology could not detect what my baby had. Any description of her anatomy would have been a false picture of her health. My baby had all 10 fingers, 10 toes, a beautiful face, picture perfect spine, lungs, heart and even a long femur bone – she would have been a tall child according to the technician reviewing the last sonogram I had at the time of receiving our diagnosis. All outwardly signs were perfect. But her neurological system and her brain were the complete opposite of normal. And yes, I am forever haunted by the words of that technician informing me that my child would have been tall.

It is demeaning and unconscionable that women in many states across the country are forced to undergo an ultrasound against their will. I am grateful I was not forced to hear a description of the pregnancy. But unfortunately, many women are - and I am heartened that Sen. Blumenthal's legislation would block those cruel forcible laws that cause so much anguish to other women.

These assaults on a women's right to choose are deplorable. Abortion access should not be a hardship, no matter what the circumstances are for women seeking this service. Women must be allowed to choose what is best for their family and for their unborn child – including abortion as a viable, affordable option.

Thank you again, Senator Blumenthal, for your bravery in introducing this proactive legislation and for creating the Women's Health Protection Act.

With admiration and respect,

Dana Weinstein

Testimony of the National Abortion Federation

and Abortion Providers in Ohio, Pennsylvania, and Tennessee

Submitted to Chairman Leahy and Ranking Member Grassley

United States Senate Committee on the Judiciary

For the Hearing on S. 1696, the Women's Health Protection Act

July 15, 2014

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The National Abortion Federation is the professional association of abortion providers in North America. NAF's mission is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women.

I. Women's Constitutional Rights are Threatened in the United States

Across the country, a woman's right to access safe, legal abortion care is in crisis. Over 200 restrictions on abortion care were enacted by states in the last 3 years[1] and 733 new restrictions have already been introduced in the 2014 legislative sessions in the states.[2] As part of a coordinated national anti-abortion political strategy, state and local legislative bodies across the United States have enacted more restrictions on abortion care between 2011 and 2014 than in the entire previous decade.[3] Collectively, these regulations form the most serious threat to abortion rights since *Roe v. Wade* affirmed a woman's constitutional right to choose. In many parts of the nation, a woman's ability to access her constitutionally protected right to abortion care depends on whether she is fortunate enough to live near a clinic or whether she has the financial means available to travel, often long distances, to reach the care that she needs. A woman's health options should not depend on her geographic location.

Since 1977, the National Abortion Federation has ensured the safety and high quality of abortion practice with standards of care, protocols, and accredited continuing medical education. As the professional association of abortion providers, our evidence-based *Clinical Policy Guidelines* (CPGs) establish the standards for quality abortion care in North America. Our members include private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices, and hospitals who together care for more than half the women who choose abortion in the United States and Canada each year.

Our providers are committed to protecting the health, safety, and well-being of women. And yet, these dedicated health care professionals have been severely affected by the onslaught of anti-choice legislation, enacted under the guise of increasing "women's health and safety." We cannot continue to allow politicians and anti-choice extremists to interfere with medical practice to the detriment of women's health. We submit this testimony in support of S. 1696, the Women's Health Protection Act. The Women's Health Protection Act is necessary to protect women's constitutional rights from these harmful state restrictions, which impose unnecessary and burdensome regulations on abortion providers and create barriers to women's access to abortion care.

II. Targeted Regulation of Abortion Providers (TRAP) Laws

NAF is opposed to regulations that are not based in evidence and standards of medical practice, and target abortion providers for provisions that do not apply to other facilities providing comparable care. Targeted Regulation of Abortion Providers (TRAP) legislation singles out abortion providers for medically unnecessary, politically motivated state regulations which are often completely at odds with evidence-

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[1] Guttmacher Institute. STATE LEGISLATION IN 2011/2012/2013 RELATED TO REPRODUCTIVE HEALTH, *available at* http://www.guttmacher.org/statecenter/updates/2011newlaws.pdf.

[2] *State Policy Trends: More Supportive Legislation, Even As Attacks on Abortion Rights Continue*, Guttmacher Inst., Apr. 9, 2014, http://www.guttmacher.org/media/inthenews/2014/04/09/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+(New+from+the+Guttmacher+Institute).

[3] *More State Abortion Restrictions Were Enacted in 2011–2013 Than in the Entire Previous Decade*, GUTTMACHER INST., Jan. 2, 2014, http://www.guttmacher.org/media/inthenews/2014/01/02/index.html?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+Guttmacher+(New+from+the+Guttmacher+Institute).

based standards of care. These laws are proffered by their anti-choice supporters as health and safety regulations. However, these laws jeopardize the safety of women, unfairly target abortion providers, and make it more difficult for women to access abortion care. Sponsors of TRAP laws imply, contrary to medical evidence, that abortion clinics are unsafe and need further regulation. This is clearly untrue. Abortion care is one of the safest and most commonly provided medical procedures in the United States, and serious complications are extremely rare.[4] The following measures are examples of the harmful regulations that would be prohibited by the Women's Health Protection Act.

A. Hospital Admitting Privileges

The Women's Health Protection Act would create federal protections against state regulations that set medically unnecessary professional requirements for physicians and other health care providers. These include laws that, as a prerequisite to providing abortion care, require medical professionals to have admitting privileges or a similar formal arrangement at a nearby hospital. Admitting privileges govern how a doctor admits patients – often via a contractual relationship between the doctor and hospital. Many states have recently passed these laws, including Alabama, Louisiana, Mississippi, North Dakota, Oklahoma, Tennessee, Utah, and Wisconsin.

NAF's *Clinical Policy Guidelines* have never required physicians to have admitting privileges at a hospital, because there is no evidence that this requirement would improve patient outcomes. Furthermore, regulations requiring physicians to have hospital admitting privileges are not supported by the medical community. Medical organizations such as the American Medical Association and the American College of Obstetricians and Gynecologists oppose admitting privileges requirements, as they do not reflect current medical practice and provide no real benefit to patients. In the rare instance that a woman would need emergency care in a hospital, the emergency room staff and on-call physicians are available to provide that care, just as they would for any other type of complication.

There are many reasons why a physician providing abortion care would not routinely have hospital admitting privileges, none of which are related to the quality of care they provide. Requirements for admitting privileges vary substantially from hospital to hospital – depending on the hospital affiliation, number of hospitalists, and administration. As such, hospitals may refuse to grant physicians privileges because of outside pressure or religious affiliation, or require physicians to live within a certain distance of the hospital, perform a minimum number of on-call days, or admit a certain minimum number of patients each year. These requirements are often insurmountable for physicians in many practice areas, including abortion care.

B. Medically Irrelevant Physical Facility Requirements

In addition to hospital admitting privilege requirements, 27 states have restrictions in place that single out abortion facilities for onerous physical plant requirements or politically motivated,

[4] *Facts on Induced Abortion in the United States*, GUTTMACHER INSTITUTE, http://www.guttmacher.org/pubs/fb_induced_abortion.html (last updated Feb. 2014).

medically unnecessary policies and equipment standards. For example, 13 states have regulations that set forth size requirements for procedure rooms and corridors. Other states have placed onerous regulations on lighting fixtures, temperature requirements, ventilation systems, and items such as landscaping or the number of parking spaces. Abortion care is a simple surgical or pill-based procedure that is typically provided in outpatient settings. These types of regulations are not evidence-based and vary substantially from what is medically necessary for the health and safety of patients, as well as what is required of facilities providing comparable medical care. Any physical plant requirements for health care facilities that provide abortion care should be based on the services provided, not on politics.

Imposing medically unnecessary physical facility requirements places a substantial burden on abortion facilities, often forcing health care providers to undertake extensive renovations that serve no medical purpose, or close their doors entirely, negatively impacting women's access to safe abortion care.

III. Legislative Interference with Evidence-Based Provision of Medication Abortion

The Women's Health Protection Act would create protections against state regulations that limit a physician's ability to prescribe or dispense drugs based on established standards of care and good faith medical judgment. Seventeen states have passed regulations that interfere with current medical practice for the provision of medication abortion.

Medication abortion is abortion induced with FDA-approved drugs mifepristone (RU-486) and misoprostol, and is most effective up to ten weeks into a pregnancy. Medication abortion allows a woman to have a safe, effective abortion without a surgical procedure. More than 2 million women in the US have chosen to have a mifepristone medication abortion since it was approved by the FDA in 2000.

As a result of numerous studies and considerations, it is now the international standard of care for medical professionals to follow an evidence-based regimen when prescribing medication abortion that differs from the FDA label. There is nothing unusual about this. The FDA does not regulate the practice of medicine – its regulatory process is a threshold for approving drugs for use. It is standard medical practice in the U.S. for medical professionals to prescribe FDA-approved drugs in dosages and for medical indications that were not specifically approved – or even contemplated – in the FDA labeling process. The FDA does not automatically update a drug label when a new standard of care is adopted by the medical community. The drug manufacturer must pay for an FDA label change. Thus, off-label or evidence-based use of medication is very common.[5] If a state were to bar all off-label drug uses, the effect would be widespread with broadly negative consequences on patient care and treatment options. Once again, anti-choice politicians have singled out abortion care for a different standard than is applied to other comparable procedures.

[5] David C. Radley et al., *Off-label Prescribing Among Office-Based Physicians*, 166 ARCHIVES INTERNAL MED. 1021, 1021-1026 (2006).

NAF's *Clinical Policy Guidelines* allow evidence-based regimens because they are safe, supported by peer-reviewed research, and use a lower dose of medication that is equally effective. Domestic and international organizations have done the same, including Planned Parenthood Federation of America, the American College of Obstetricians and Gynecologists, the World Health Organization, and the Royal College of Obstetricians and Gynecologists. Regulations of medication abortion that limit use to the FDA protocol are out of step with the medical standard of care and do nothing to improve the health and safety of women. These regulations were designed to limit access to a safe, effective abortion option by requiring an outdated medical practice.

IV. TRAP Laws Will Continue to Erode Women's Constitutionally-Protected Rights

In states like Tennessee, Mississippi, Alabama, Arkansas, Texas, Oklahoma, Louisiana, North Dakota, and Ohio, abortion restrictions have eroded the availability of abortion care to critically low levels. Enactment of TRAP laws discourages health care providers from offering abortion care by making provision overly burdensome and expensive. In 2011, 89% of counties in the United States were already without an abortion care provider.[6] Further decreasing access to abortion care with politically motivated restrictions jeopardizes women's health. Unfortunately, low-income women and women of color disproportionately bear the burden of these restrictions.

We urge you to support every woman's right to access safe, legal abortion care, and pass the Women's Health Protection Act.

V. Testimony of National Abortion Federation Members from Ohio, Pennsylvania, and Tennessee on the Impact of Anti-Abortion TRAP Laws

Testimony of Chrisse France, Med, Executive Director,
Preterm, Cleveland, Ohio
In support of the Women's Health Protection Act, July 15, 2014

My name is Chrisse France, and I am the Executive Director of Preterm, an independent, nonprofit abortion care clinic in Cleveland, Ohio. Preterm is an Ohio state-licensed ambulatory surgery center (ASC) that provides abortion care and reproductive health services for 5,000 women annually. We have served the women of Cuyahoga County, Northeast Ohio, Western Pennsylvania, and beyond since 1974. We provide compassionate, high-quality abortion care and related services in a safe and comfortable environment.

Since 2011, Ohio has enacted some of the most challenging restrictions to abortion access in the country. That year, we were required to begin using only the FDA-approved regimen for medication abortion with mifepristone and misoprostol. Clinics and physicians in every state, including Ohio, have used the more effective and better-tolerated evidence-based regimen since FDA-approval in 2001. Using evidence-based regimens that vary from the FDA label is very common in all fields of medicine.

[6] RACHEL K. JONES & JENNA JERMAN, GUTTMACHER INST., ABORTION INCIDENCE AND SERVICE AVAILABILITY IN THE UNITED STATES, 2011, 1 (2014), *available at* http://www.guttmacher.org/pubs/journals/psrh.46e0414.pdf.

Now, however, Ohio doctors are forced to use the less effective and more expensive FDA-approved regimen. As a result, women have to make a total of four clinic visits, instead of two. And rather than taking the second medication – misoprostol – at home, women are now required to take the medication at the clinic. Prior to this requirement, women took misoprostol at home, which is preferable so that they can complete the abortion in the privacy and comfort of their own home and not have to travel during this time when they may be experiencing cramping and bleeding. Also, the FDA-approved regimen requires three times the dose of mifepristone than what is effective under the evidence-based regimen.

By preventing a physician from using a safe and effective alternative to the FDA-approved regimen, this law takes away their medical decision-making capabilities and legislates how physicians can practice medicine. Likewise, the law takes away the decision-making capacity of their patients.

In 2010, 624 women chose to have a medication abortion at Preterm. In 2011, that number dropped to 345, and then to 90 the following year. There was a corresponding increase in surgical abortions, indicating that women do not change their minds about their abortion decision, regardless of the restrictions and attempts to limit their access.

Consider a woman who makes the decision to have an abortion in Ohio, which more than 24,000 women did in 2012. These are the legislative and regulatory barriers she faces:

- If she is low-income she must gather enough cash because Medicaid and most insurance companies will not pay for her abortion. The cost is around $400 for a first trimester abortion and more than $1,000 if she is in her second trimester.
- She then makes her first of at least two appointments. She has to walk through a gauntlet of mostly older male protesters who scream at her “not to kill her baby.”
- She has to be offered Ohio state government-mandated resources about birth and adoption. She may accept or refuse the materials. Almost everyone declines.
- She must be informed of the gestational age of her pregnancy and whether or not a heartbeat is heard, offered the opportunity to view or hear the heartbeat on an ultrasound, and be informed as to the probability, based on her gestational age, of carrying the pregnancy to term. This often makes women cry, but it does not change their minds; it just makes them feel shamed and stigmatized.
- She must wait more than 24 hours before having her abortion.
- If she chooses medication abortion she must make a total of four visits to the clinic. If she is beyond 16 weeks, her abortion will take place over three days. All other women must make at least two visits.

Ohio also has a requirement that every ASC must maintain a written transfer agreement with a local hospital. Due to another state requirement, public hospitals are forbidden from entering into transfer agreements with abortion clinics. That poses a nearly impossible hurdle for providers in communities where the only hospital is a public hospital or part of a Catholic hospital system. This requirement is unnecessary and burdensome, and does absolutely nothing to improve the quality of care. The risk of

complications requiring hospitalization for a first trimester abortion are 0.71 per 1,000 women, far safer than most surgical procedures.[7] While transfers are extremely rare, hospitals are required to accept patients, regardless of from where the patient is transferred. Hospital transfer agreements should not be susceptible to political pressure from groups with an agenda other than absolute patient safety. However, this is exactly what is happening in Ohio as the only ASCs that have been unable to obtain a transfer agreement are abortion clinics. Because of the politicized process, the requirement to obtain and update a transfer agreement annually is onerous and unnecessary, for both the hospital and the ASC.

Although I believe that all health care facilities should be expected to maintain the highest quality of care and that inspections help ensure high quality care, the requirements that I have discussed in my testimony are both burdensome and medically unnecessary. My clinic already abides by a number of federal and state laws, and has been licensed in the state of Ohio as an ASC since 1997. Additionally we are accredited by a number of professional associations, including the Accreditation Association for Ambulatory Health Care (AAAHC). Accreditation is a voluntary process through which an ambulatory health care organization is able to measure the quality of its services and performance against nationally recognized standards. The accreditation process involves self-assessment by the organization, followed by thorough on-site review by the AAAHC's expert surveyors, who are themselves, health care professionals. Likewise, Preterm is a member of the National Abortion Federation and the Abortion Care Network.

In the past year, four Ohio clinics have closed and three more are appealing mandates to close because of the transfer agreement requirement. Cincinnati may soon be the largest metropolitan area in the country without an abortion provider. Women, especially low-income women and those with health conditions, already have to travel considerable distance to receive abortion care. Ohio women deserve better, and the Women's Health Protection Act is necessary to protect women – including Preterm's patients – from additional harmful state restrictions, which impose unnecessary and burdensome regulations on abortion providers and create barriers to women's access to abortion care.

Testimony of Kim F. Chiz, RN, BSN, Director of Nursing,
Allentown Women's Center, Allentown, Pennsylvania
In support of the Women's Health Protection Act, July 15, 2014

Since 1978, the Allentown Women's Center, now located in Bethlehem, Pennsylvania, has provided reproductive health care services, including abortion care, to a large geographic region extending well beyond our home in the Lehigh Valley. Most of the counties in Pennsylvania have no abortion care provider and many of our patients spend long hours in cars and buses to obtain the care they need.

[7] *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Edited by Maureen Paul, MD et al. Wiley and Sons, 2009

Some of them come from Pike, Luzerne, Bradford, Lackawanna Counties, and the coal regions of Central Pennsylvania. Some travel from as far as Western New Jersey, Southern New York, the state of Delaware, and the Pennsylvania cities of Williamsport and State College.

Even without anti-choice legislation, our patients face many obstacles in obtaining abortion care. Hurdles can include: child care; lack of funds, which often forces patients to borrow money or spend their savings; severe weather; juggling work and school; and transportation, which often includes finding someone to drive them home and/or often travel three or more hours to reach us. When they arrive at our clinic, they must drive or walk past the aggressive, shouting bullies who often make them feel scared, threatened, and shamed. If they have insurance, it often does not pay for their abortion care. Many must take unpaid time off from work or school to get here. Even though *Roe vs. Wade* legalized abortion care in 1973, these are some of the obstacles Pennsylvania women have always had to surmount in order to maintain their reproductive autonomy. Before 1973, Pennsylvania women had abortions. The lucky ones traveled to states where it was legal or found competent medical practitioners to help them illegally, closer to home. The unlucky ones died by their own hands or by those of an unsafe, untrained person. Women have always needed access to abortion care and they always will.

In 1982, Pennsylvania increased the number of unnecessary, burdensome provisions that a woman must overcome to obtain abortion care with the passage of the Abortion Control Act, which the Supreme Court of the United States upheld in *Planned Parenthood v. Casey* in 1992. As a result, our patients have unnecessarily tolerated waiting periods and a parental consent requirement, and have listened to Pennsylvania state-mandated information which often has nothing to do with their circumstances. They have been belittled by their government's assumption that they do not know what happens inside their own bodies during pregnancy. Women under 18 years of age, who were unable to obtain parental consent because of domestic violence, have sat before judges to request permission to access basic health care services. Yet they continue to need us.

While the burdens imposed by the Abortion Control Act will not be alleviated by the passage of the Women's Health Protection Act, its passage would provide some very real protections for Pennsylvania women, particularly against the targeted regulation of abortion providers (TRAP) that reduces access to abortion care. For example, it would block the passage of an unnecessary and dangerous Hospital Clinical Privileges Bill which is currently pending in Pennsylvania's State Legislature. This bill would require physicians who provide abortion care to establish a business contract with a hospital, which can be nearly impossible to get due to the politicized process, and is unnecessary and does not improve patient safety. Our physicians are already board certified, our nurses have professional licensure, and our staff already provides safe and compassionate care.

These requirements are unnecessary as, in the highly unlikely event a complication does occur, Pennsylvania abortion clinics already have transfer agreements with local hospitals in place to handle these complications. Also, the bill targets only physicians who are providing abortion care, which has an incredible safety record, unparalleled to surgical procedures that would not be covered in this bill. This privileges bill would not apply to gastroenterologists providing colonoscopies, orthopedic surgeons

performing complex out-patient surgical repairs or any other physician operating outside of a hospital. Instead, the true intent of the bill is to close Pennsylvania abortion clinics, as we have seen in other states.

Not only would WHPA provide protection against admitting/clinical privileges laws, but also against medically irrelevant physical facility requirements. In 2011, the Pennsylvania State Legislature passed a law that requires abortion care providers to meet the requirements of Ambulatory Surgical Centers (ASC). ASCs provide a wide variety of surgical procedures that are more complicated than abortion care, including sterile orthopedic, ophthalmologic, gastroenterological, and cosmetic surgeries. Abortion care is a simple procedure that does not necessitate large sterile fields or high-tech air flow systems. Despite the clear differences between a true ASC and our abortion clinic, we have been required to meet these regulations.

Finally, this ASC TRAP law resulted in the closure of many Pennsylvania abortion clinics. Additional clinics were required to cut back the services they offer and can no longer provide later care. This has made a long trip even longer for many women and increased their already burdensome expenses. We have already heard reports of women self-inducing abortion through herbal medications and ordering black market medications from dubious internet sources. The passage of additional TRAP laws has not – and will not – make women safer, it will do the very opposite. When women cannot access safe and legal abortion, they will turn to other means.

Passage of the Women's Health Protection Act will protect our patients from additional state laws which do not improve their safety, but instead close clinics and add to the burdens women already face. This would not be the first time federal legislation could help to protect women. In 1994, the federal government acted to protect our patients from clinic violence and harassment through the Freedom of Access to Clinic Entrances (FACE) Act. We are in need of a federal protection again. Due to the onslaught of state legislation nationwide that imposes medically unnecessary and burdensome regulations on abortion providers and creates barriers to women's access to abortion care, it is time for a federal law that will protect women's constitutional rights, and the Women's Health Protection Act would do just that.

Testimony of Katy Leopard, Director of Community Partnerships,
Choices: Memphis Center for Reproductive Health, Memphis, Tennessee
In support of the Women's Health Protection Act, July 15, 2014

My name is Katy Leopard and I work at Choices: Memphis Center for Reproductive Health in Memphis, Tennessee, as the Director of Community Partnerships. For 11 years I was a stay at home mother of three children, PTA President, and active volunteer in my church. Memphis, Tennessee, is a city of exceptional beauty and a unique, gritty, southern charm. Memphis is also a city of desperate poverty and racial disparity and it was those issues I wanted to address when I went back to work. Choices is an independent, non-profit, community health center founded in 1974 following the Roe v. Wade Supreme Court ruling. The agency's mission is to empower individuals in the Mid-South community to make

informed choices for and about their reproductive health. Choices is working to build a comprehensive reproductive medical practice that provides a range of sexual and reproductive health services for more than 3,000 women, men, and teens each year.

Women do not come to Choices because they want to have an abortion. They come because they do not want to be pregnant. Or because a pregnancy is not sustainable, or because it would endanger their health. Some of them see that having a baby right now will cause them to have to quit the job they just got, or withdraw from the college they just entered, or further aggravate an already dangerous family situation at home. They come to us from Mississippi, Arkansas, and beyond not because they want to spend some time visiting Memphis, or because they have a caring primary care physician who could meet their needs at home but referred them to us instead, or because a family friend knows our doctor. They come because they are desperately trying to stay in control of their lives. The Women's Health Protection Act can help these women.

The women who come to Choices often cannot pay for their care without assistance. They often have to provide written excuses to bosses who want to know why they have to miss a day, and often have to scrape together gas or hotel money in order to pay to travel long distances to have a procedure which is legal but highly stigmatized. They have to park next to and pass by people who yell at them through megaphones, call them murderers, and reach into their car windows. Every day there are men and women who come to Choices for regular wellness exams, STI testing and treatment, pregnancy planning help or pregnancy prevention counseling. The Women's Health Protection Act can help these people.

But not if Choices does not exist.

Recently in Tennessee the state legislature passed a law requiring that doctors who perform abortions have hospital admitting privileges. This medically unnecessary law has had disastrous consequences for abortion access in communities in which religiously affiliated hospitals refuse to offer privileges to physicians who provide abortions. Private hospitals have no accountability to the community and should not have this power over women's access to abortion. Luckily, Choices' physician has admitting privileges but another clinic providing abortions in Memphis was forced to close as a result of this law, severely straining current capacity. In Tennessee, a woman has a short window in which to determine if she is pregnant and then to make a decision to continue the pregnancy or not. Because of the more limited capacity now in the Mid-South area, many women are not able to schedule an appointment before they are too far in their pregnancy. This forces a woman to carry an unwanted pregnancy to term or to travel even greater distances at greater expense to obtain an abortion.

Under another law specifically targeted at abortion providers in Tennessee, Choices is required to be licensed as an ambulatory surgical center. This requirement insists that Choices be outfitted with medically unnecessary but expensive building requirements. Forcing clinics to meet ambulatory surgical center standards, even if they only do first-trimester abortions, which can be done in a short procedure or with a pill, is yet another attempt by the Tennessee Legislature to prohibit women from accessing safe and legal abortion care.

Many other laws already passed by the Tennessee state legislature would have closed the doors of Choices. Thankfully, the Tennessee Supreme Court has ruled these laws in violation of the state constitution. In November, voters in Tennessee will decide on a change to that constitution, which would open the door for increasingly restrictive laws designed to shut clinics like Choices down. Under the guise of "protecting women's health" these new laws would legislate Choices and a women's constitutional right to safe and legal abortion out of existence in Tennessee.

The Women's Health Protection Act can help the women of Tennessee. We urge you to pass it.

Stories of Those Who Have Suffered when Politicians Interfere in Women's Personal Health Decisions

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Danielle Deaver
Nebraska

"I want my daughter's life — and the tragic circumstances surrounding her death — to stand for something."

At 22 weeks, Danielle Deaver's water broke prematurely. She and her husband Robb learned she'd experienced a spontaneous rupture of her membranes, resulting in the loss of most of the amniotic fluid surrounding the fetus. From that point, her body was unable to retain any fluid, which a doctor told her would result in little or no further lung development, inability for limbs to develop properly, and less than a 10 percent chance the fetus would survive after delivery. The doctor could not legally induce labor due to Nebraska law, and told Danielle to wait for the start of labor. Danielle went into early labor at 23 weeks, and post-delivery pathology showed that she had begun to develop an infection. Her baby was alive for 15 minutes.

Chantelle Kendall
Utah

"It was on a Friday, and it was at 3:00 o'clock, and by the time the radiologist read us the report it was 5:00. I had to wait a week, being pregnant, feeling this baby kick, it was such a nightmare.

Chantelle and her husband Richard were elated about her pregnancy. Everything was going fairly well until about the 17th week, when a radiologist told the couple that their baby had severe brain defects and that "if the baby survived through delivery he would almost certainly live a life of suffering, requiring a feeding tube and round-the-clock care." Chantelle and Richard made the devastating decision to terminate the pregnancy. Because of the timing of their initial report from the radiologist, and because Utah legislators had recently passed a provision mandating a 72-hour waiting period for a woman seeking an abortion, Chantelle was forced to continue her pregnancy for an additional agonizing week.

Liz Read-Katz
Missouri

"This was the hardest and saddest decision I have ever made but one that I made because it was in my best interest, my family's best interest and because I loved my baby so much that I couldn't stand the thought of her being born in pain and agony and only to ever see the walls of a hospital.…An additional 72 hour wait, extra ultrasounds, mandatory videos would not have changed my mind, they would have just caused me more pain than I was already going through."

Liz and her husband were ecstatic about her pregnancy. But after genetic testing at about 16 weeks, Liz received a call from her doctor notifying her that her that chances of having a child with Trisomy 18 had gone from 1 in 3,000 to greater than 1 in 10. A high-resolution ultrasound at 17 weeks, 1 day found a heart defect, digestive issues, and markers for Trisomy 18. Amniocentesis confirmed that Liz's baby had Trisomy 18, which her genetic counselor told her is considered incompatible with life. She and her husband made the heartbreaking and difficult decision to terminate her pregnancy. After the procedure, her doctor informed her all of the baby's large joints had been formed incorrectly and "had he been born alive he would have been born in agony," and the day after, she learned from her genetic counselor that her baby's external sex organs had also not formed properly.

Christie Brooks
Central Virginia

"My husband and I were confronted with two equally horrible options — carry the pregnancy to term and watch our baby girl suffocate to death upon birth, or terminate the pregnancy early and say goodbye to our much-wanted and much-loved baby girl."

Christie was pregnant with her second child, a planned and wanted pregnancy. After a 20 week ultrasound, she found out her daughter would be born with a severe structural birth defect called congenital diaphragmatic hernia (CDH), and would suffocate at birth. She made the difficult decision of ending the pregnancy at 22 weeks.

Judy Shackelford
Wisconsin

"'I know what it is like to live without a mother,' Shackelford says. 'My mother died when I was only four years old, and it changed my life forever.'"

Four months into her pregnancy, Judy developed a pregnancy-induced blood clot in her arm. The only guarantee that she wouldn't die and leave behind her five-year-old son was for Judy to terminate the pregnancy. She and her husband made the very difficult decision to terminate the pregnancy.

Cecily Kellogg
Pennsylvania

Cecily was 23 weeks pregnant with her twin sons, Nicholas and Zachary. She was suffering from a number of health complications when she found out they were symptoms of preeclampsia. Cecily went in for an ultrasound with her husband, where they found out one of their sons had died. Her health worsened rapidly, and after doctors failed to stabilize her condition, Cecily and her husband were told they would have to terminate the remaining pregnancy to preserve her life.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 14, 2014

Dear Chairman Leahy and Ranking Member Grassley:

As national, state, and local organizations committed to women's reproductive health, rights, and justice, we write in support of the **Women's Health Protection Act of 2013**.

Despite the clear constitutional rights established more than four decades ago in the landmark Supreme Court decision *Roe v. Wade*, each year politicians across the country pass harmful restrictions in an effort to roll back a woman's right to make the best health care decisions for herself and her family. Any one of these restrictions imposed on health care providers and abortion services can have a devastating impact on the women affected by it. But when all of these various attempts to block access to abortion work together, the effect is often catastrophic—making a range of essential reproductive health care virtually impossible to obtain for far too many women.

Every pregnant woman faces her own unique circumstances and potential challenges, and she must be able to make her own decisions based on her personal values, the advice of the medical professionals she trusts, and what's right for her family. In recent years, however, politicians have increasingly sought new ways to interfere with personal decision-making and undermine women's access to abortion care. State legislatures have been more active than ever in passing burdensome requirements that single out abortion providers and services and do nothing to advance women's health or safety —and, in fact, ultimately jeopardize women's health. States enacted a record-breaking 92 restrictions on abortion in 2011, and over 100 additional dangerous and unnecessary measures have passed into law since then.

Examples of restrictions on abortion that have been enacted with increasing frequency in recent years that single out abortion services and impede access include:

- Requirements that health care providers perform tests and procedures even if they are not medically necessary;
- Measures that force health care providers to follow outdated medical guidelines rather than follow the current standard of care;
- Prohibitions on expanding access to women in rural areas through telemedicine;

- Requirements imposed on health care facilities that perform abortion that normally apply to hospitals or ambulatory surgical centers;
- Requirements that physicians at abortion clinics maintain admitting privileges at local hospitals, despite the safety of abortion and the fact that admitting privileges are not necessary in the event of a complication;
- Measures that require a woman seeking an abortion to make multiple unnecessary trips to the abortion provider; and
- Making a woman visit an anti-abortion "crisis pregnancy center."

A woman's constitutional rights should not depend on her zip code. But the legislative attacks on reproductive health care have made it so that women in some parts of the country have diminished access to essential reproductive health care. We need a federal law that would make these restrictions unlawful, thus allowing medical providers to do the important work of providing safe, legal, high-quality health care to all women across the country. We need the **Women's Health Protection Act**. We thank you for calling a hearing on this critical legislation and pledge our support in working toward its passage.

Sincerely,

Abortion Care Network
Alliance for Justice
American Association of University Women
American Civil Liberties Union
American Congress of Obstetricians and Gynecologists
Association of Reproductive Health Professionals
Atlanta Women's Center
Black Women's Health Imperative
Blue Mountain Clinic Family Practice
Catholics for Choice
Center for Reproductive Rights
Center on Reproductive Rights and Justice at UC Berkeley School of Law
Cherry Hill Women's Center
Civil Liberties and Public Policy
Delaware County Women's Center
Feminist Women's Health Center
Hadassah, The Women's Zionist Organization of America, Inc.
Hartford GYN Center
Ibis Reproductive Health
Jewish Women International
Law Students for Reproductive Justice
Medical Students for Choice
MergerWatch Project

NARAL Pro-Choice America
National Abortion Federation
National Asian Pacific American Women's Forum
National Council of Jewish Women
National Family Planning & Reproductive Health Association
National Health Law Program
National Latina Institute for Reproductive Health
National Network of Abortion Funds
National Partnership for Women & Families
National Women's Law Center
National Women's Health Network
Northland Family Planning Centers, Michigan
Nursing Students for Choice (NSFC)
Oklahoma Coalition for Reproductive Justice
People For the American Way
Philadelphia Women's Center
Physicians for Reproductive Health
Planned Parenthood Federation of America
Population Connection
Presidential Women's Center
Religious Coalition for Reproductive Choice
Reproductive Health Access Project
Reproductive Health Technologies Project
Sexuality Information and Education Council of the U.S. (SIECUS)
South Carolina Coalition for Healthy Families
Southwest Women's Law Center
Trust Women/Silver Ribbon Campaign
Tucson Women's Center
Whole Woman's Health
Wisconsin Alliance for Women's Health
Women's Medical Fund (Pennsylvania)

United States Senate
Committee on the Judiciary

Hearing
"S.1696, The Women's Health Protection Act:
Removing Barriers to Constitutionally Protected Reproductive Rights"

Testimony Submitted for the Record by the Undersigned Organizations

July 22, 2014
Washington, DC

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 22, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

We, the undersigned reproductive justice advocates,[1] write in support of the Women's Health Protection Act, which protects a woman's ability to obtain abortion services by dismantling many of the barriers that currently exist for women seeking this important health care. Every woman faces her own unique circumstances, challenges, and potential complications, and must be able to make her own decisions based on her doctor's advice, her personal values, and what is best for her and her family. Every woman needs affordable and accessible pregnancy-related care, including abortion, regardless of where she lives and notwithstanding her economic, political, or personal situation. We urge Congress to pass the Women's Health Protection Act, and uphold our nation's promise of equal rights under the Constitution, so that every woman can make personal reproductive health decisions with dignity.

Despite the clear constitutional rights established in *Roe v. Wade*, a growing number of women are finding it increasingly challenging to access abortion care. In our communities throughout the country, it has become extremely difficult for women to safely and legally end a pregnancy because states have enacted laws singling out reproductive health care for onerous regulations that are not imposed on other areas of medicine. Lower income women, women of color, and young women are more likely to experience unintended pregnancy and therefore more likely to need abortion services than affluent white women: these outcomes are caused by socioeconomic disadvantage, lack of access to family planning, persistent forms of racism and other structural barriers to care, and mistrust in a medical system that has a history of discrimination and disparate treatment.[2] As a result, restrictions on abortion care amplify existing health disparities, disproportionately harming women who already face barriers to accessing quality health care, due to their socioeconomic status, gender, and race.

We can protect women's health and well-being by ensuring that every woman has access to the reproductive health care she needs. Restrictions imposed on health care providers and abortion services impede meaningful access to essential services to the detriment of public health — particularly for women who are already disadvantaged by systems of economic and racial oppression. According to a recent survey of state health departments, more than 50 abortion clinics have closed or stopped providing abortion since the 2010 onslaught of legislative attacks on reproductive health services began around the country.[3] In Mississippi, for example, a medically unnecessary admitting privileges law creates a significant obstacle to receiving care.

Mississippi is the poorest state in the country and is one of the reportedly five states that have only one remaining clinic.[4] Many patients of the sole Mississippi clinic already take on the burden of cost and two to three hours of travel to receive care.[5] The 2012 law would close the last remaining clinic in the state and would force women to venture out of state to access care.[6] For now, the clinic remains open while the case is pending in federal court.

The distance women must travel to reach an abortion provider negatively impacts their ability to access reproductive health services. Eighty-two percent of U.S. counties do not have abortion services and 74 percent of women living in rural areas must travel more than 50 miles to get to the nearest abortion clinic.[7] Rural women are doubly burdened by lack of access to care: not only due to a lack of providers, but also because 95 percent of U.S. counties that exhibit persistent patterns of poverty are in rural areas.[8] In 2008, one-third of U.S. women reported travelling more than 25 miles to reach a clinic and women in states with mandatory counseling and waiting period requirements were more likely than their peers to travel even further.[9] Despite strong evidence that medication abortion can be safely prescribed via telemedicine and dispensed by trained nurses, state legislatures have specifically targeted the way that women in rural areas access abortion by restricting the mode by which they receive the medicine and the medical professional who dispenses it.[10]

Every woman deserves to make informed decisions about her health care based on scientifically accurate information from a doctor she trusts, free from discrimination. Race and sex-selective abortion bans encourage medical professionals to scrutinize women based on racial or ethnic background, based only on stereotypes.[11] Such bans do nothing to address the true causes of racism and sexism; rather, they open up the floodgates to anti-immigrant and racist sentiments based in stereotypes about the Asian American community and about a black woman's ability to determine the best course to take in her reproductive health care.

Furthermore, women should not be mandated to receive or listen to false information prior to receiving care – not only because it is medically inaccurate, but also because restrictions requiring multiple visits unnecessarily increase the expense of the procedure. State-mandated biased counseling serves no purpose other than to intimidate and stigmatize women seeking medical treatment. Such laws have been proven to drive up the cost to women, thereby preventing services to some women and delaying care into the second trimester when the procedure is less safe.[12] African American women are regularly the target of misleading and false information intended to dissuade them from choosing abortion: for example, anti-abortion organizations often claim that communities of color are being targeted by abortion providers in order to commit "black genocide."[13] Finally, our nation's youth are in special need of medically accurate information about reproductive and sexual health: for example, research shows that Asian Pacific American teens are less likely to communicate with their medical provider about sexuality and risk prevention than any other ethnic group.[14]

A woman cannot make a meaningful decision about whether to become a parent if safe, legal, available, and affordable abortion services are out of reach. Approximately 69 percent of women obtaining abortions live close to or below the federal poverty level and 42 percent of those women reported income qualifying them as poor, meaning that they have income below 100 percent of the federal poverty line.[15] Poor women who decide to have an abortion often have to

wait many weeks to have the procedure while they raise the necessary funds and this wait drives up the cost and increases the risk of the procedure.[16] Women commonly cite financial barriers as leading to a delay in getting an abortion and if a woman is ultimately unable to afford the procedure, she may be forced to carry her unwanted pregnancy to term.[17] Furthermore, a woman working to raise the necessary funds must often divert money from paying for food, rent, or utilities, and harmful restrictions such as mandatory counseling and waiting periods compound the cost for women due to lost wages and added childcare and transportation expenses.[18] Moreover, young and low-income women are most likely to experience such delays, and thus mounting costs, due to procedures performed later in pregnancy.[19] Furthermore, research shows that women who carry unwanted pregnancies to term because they are denied care due to gestational age are three times more likely to fall below the federal poverty line within two years.[20]

Our government has a particular responsibility to ensure that women who have limited access to affordable health care can receive the same quality of care as those with means. Due to the link between institutional racism and socioeconomic disadvantage, women of color are at higher risk of living in poverty and are more likely to lack access to regular, high-quality family planning and other health care services.[21] Women of color are disproportionately affected by restrictions that increase the cost of an abortion because they are more likely than white women to experience unintended pregnancy,[22] to seek abortion care,[23] and to qualify for public insurance.[24] Sixty-six percent of women who have an abortion have some form of health insurance, but 57 percent report paying out of pocket, largely because many forms of state and federal Medicaid do not cover abortion.[25] Restrictions also unduly affect immigrant women, who are more likely to live in poverty than women born in the United States, and are routinely denied access to health care coverage, including abortion coverage.[26] In fact, low-income immigrants who qualify for Medicaid are excluded from coverage for their initial five years of residence.[27] Undocumented women are unjustly excluded from federal Medicaid benefits and cannot even purchase health plans at full price in state insurance marketplaces.[28] Such barriers to care are not only unfair, but are also flawed public health policy, preventing immigrants from maintaining their health and that of their families.

It should be noted that the reproductive health disparities affecting our communities are broader than high unintended pregnancy rates. More consistent exposure to medical care could improve health outcomes that significantly impact our communities, especially with regards to maternal mortality, HIV prevention, and earlier detection of cancers. Maternal mortality is highly pronounced for African American women, as they are three to four times more likely to die from pregnancy related causes than white women, a risk that is compounded by lack of access to contraception.[29] Lower income women and women of color are also less likely to receive routine exams such as mammograms and pap smears that improve early detection of life-threatening conditions. Most likely due to late detection and the prohibitive cost of care, African American women are more likely than any other group of women to die from breast cancer and Latinas are more likely to be diagnosed in a later stage of cancer when it is harder to treat than are white women.[30] Moreover, the racial disparity of HIV infection is stark: African American women are twenty times more likely than white women to be infected with HIV.[31] One in thirty-two African American women will be diagnosed with HIV in their lifetimes.[32]

Taken together, the barriers to accessing safe, legal, affordable abortion care, free from medically unnecessary restriction, are formidable and seriously undermine women's health, human rights, dignity, and self-determination. The Women's Health Protection Act would begin to address some, though not all, of these barriers, focusing on dismantling the restrictions aimed at closing clinic doors and making it more difficult and less dignified for women to access this care. We believe that this legislation, in combination with separate, but parallel efforts to restore insurance coverage for abortion, protect abortion access for young people, and eliminate violence against providers, will bring us closer to a landscape where every woman is able to get the health care she needs, regardless of her circumstances.

Every woman has the right to good health and well-being for herself and her family. But for too long, the reproductive health care needs of our communities have been undermined by inaccessibility of care, prohibitive costs, discrimination, and medically unnecessary and restrictive legislation. Study after study by national and international experts show that restrictions on abortion don't reduce its frequency, but rather delay or prevent women's access to the procedure. Every woman needs affordable and accessible pregnancy-related care, including abortion, regardless of where she lives and notwithstanding her economic or racial status or her personal situation. We urge Congress to act now and pass the Women's Health Protection Act.

Sincerely,

Abortion Rights Fund of Western Mass
ACCESS Women's Health Justice
Bay Area Doula Project
Black Women's Health Imperative
California Latinas for Reproductive Justice
Center on Reproductive Rights and Justice at Berkeley Law at University of California
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Forward Together
The Lilith Fund
Ms. Foundation for Women
National Asian Pacific American Women's Forum
National Latina Institute for Reproductive Health
New Voices Pittsburgh: Women of Color for Reproductive Justice
New Voices Cleveland: Women of Color for Reproductive Justice
Oklahoma Coalition for Reproductive Justice
Political Research Associates
Provide
Raising Women's Voices for the Health Care We Need
Religious Coalition for Reproductive Choice
SisterReach
SisterSong Women of Color Reproductive Justice Collective
SPARK Reproductive Justice NOW
Surge Northwest
Women's Medical Fund

Endnotes

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NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH
Salud | Dignidad | Justicia

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 21, 2014

Dear Chairman Leahy and Ranking Member Grassley and Members of the Senate Judiciary Committee:

We thank the Committee for holding a Congressional hearing on S.1696, "The Women's Health Protection Act of 2013" and for providing advocates the opportunity to provide written testimony on this important piece of legislation. We believe the Women's Health Protection Act is critical in ensuring access to the full range of reproductive healthcare, including abortion care, for all women, particularly Latinas, regardless of where they live. We are honored to submit the enclosed testimony.

We hope to draw the Committee's attention to the negative impact that restrictions on abortion care have on Latinas and how these restrictions compound the health inequities that Latinas, their families, and their communities currently experience. For instance, in states such as Texas, Latinas disproportionately experience a wide range of health problems and treatable diseases, such as cervical cancer. Restrictions on reproductive healthcare, including abortion care, contribute to the negative health outcomes of these women by delaying access to needed care and limiting access to providers and other sources of care.

Finally, restrictions on abortion care are out of step for what most Latinos/as think regarding political interference in Latina decision-making. Seventy-four percent of registered Latino/a voters agree that a woman should be able to make her own personal, private decisions about abortion care without political interference.[1]

[1] Lake Research Partners, Reproductive Health Technologies Project & National Latina Institute for Reproductive Health. Poll: Latino Voters Hold Compassionate Views on Abortion; 2011: 1. Available at: http://latinainstitute.org/Latinopoll. [Last accessed on July 9, 2014].

NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH
Salud | Dignidad | Justicia

Again, thank you for this opportunity to submit written testimony. We believe the Women's Health Protection Act can provide Latinas and other women of color one more tool in achieving health equity. A woman's zip code should not determine the healthcare she receives.

Sincerely,

Jessica González-Rojas
Executive Director

Enclosure: NLIRH S. 1696, "The Women's Health Protection Act of 2013" Testimony

CC: Laurel Sakai and Rose Goldberg
Office of United States Senator Richard Blumenthal

CC: Kristine Kippins
Federal Policy Counsel
Center for Reproductive Rights

NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH
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S.1696 "Women's Health Protection Act of 2013"
Testimony submitted by
Jessica González-Rojas
National Latina Institute for Reproductive Health

U.S. Senate
Senate Judiciary Committee
July 21, 2014

Dear Chairman Leahy and Ranking Member Grassley and other distinguished members of the Senate Judiciary Committee:

I am honored to submit this testimony on behalf of the National Latina Institute for Reproductive Health.

The National Latina Institute for Reproductive Health (NLIRH) strongly urges the committee to support S.1696, the "Women's Health Protection Act of 2013." S.1696 will help ensure that women of color, particularly Latinas, are able to receive safe, legal, and quality reproductive healthcare regardless of where they live. NLIRH is the only national reproductive justice organization dedicated to building Latina power to advance health, dignity, and justice for 26 million Latinas, their families, and communities in the United States through leadership development, community mobilization, policy advocacy, and strategic communications.

Over the years, state politicians have passed several laws that erode access to the full range of reproductive healthcare, including abortion care, for women when they need it. So far in 2014, 13 states have passed 21 restrictions on abortion care.[i] For instance, Florida recently amended its state laws to further diminish a woman's ability to access late-term abortion care only if a woman's life or physical health is threatened.[ii] This restriction may impact the over 4.3 million Latinos/as that live in Florida.[iii] Other restrictions that impact Latina health include: prohibitions on the use of telemedicine to expand access to healthcare for women in rural areas; requirements that effectively force a woman seeking abortion care to make multiple trips to a provider; requirements on reproductive healthcare facilities that provide abortion care that mainly apply to hospitals or ambulatory surgical centers; and several others. The Women's Health Protection Act is needed to reverse the harmful impact of these restrictions so that providers are able to give quality, reproductive healthcare to all Latinas.

State level restrictions on abortion services create additional barriers to quality, healthcare for women of color, including Latinas. These restrictions exacerbate current health inequities these communities face and contribute to

negative health outcomes.

As of now, more than 33 percent of Latinos/as do not have health insurance.[iv] Almost a quarter of Latinas live at or below the poverty level,[v] and over 40 percent of Latina headed family households live below the poverty level.[vi] Due to such high rates of poverty, for many women of color, they will need federal insurance coverage to meet their health care needs. As of now, 3 in 10 Latinas qualify and are enrolled in Medicaid.[vii]

Additionally, Latina communities suffer from disproportionately high rates of preventable and treatable reproductive health conditions. Nationally, Latinas are diagnosed with cervical cancer at nearly twice the rate of non-Latina white women.[viii] Latinas also experience disproportionately high rates of unintended pregnancy[ix] and sexually transmitted infections including HIV.[x] Access and cost of care, are among several attributing factors. In fact, 57% of young Latinas ages 18-34 have struggled with the cost of prescription contraception, making it highly likely that they will not be able to use contraception on a regular basis.[xi]

Geography also plays a role in determining the health outcomes of Latinas. In Texas, Latinas report a higher rate of health concerns, such as diabetes, cardiovascular disease, obesity, and cancer mortality, than Latinas nationally.[xii] Additionally, Texas women experience cervical cancer at a rate 19 percent higher than the national average, but Texan Latinas also have a higher incidence of cervical cancer than their white or Black peers in the state.[xiii] Immigrant Latinas in Texas are also more likely to experience cervical cancer.[xiv] Women living in counties bordering the Texas-Mexico border are 31 percent more likely to die of cervical cancer compared to women living in other counties.[xv] In Texas, where Latinos are three times as likely to live in poverty as whites,[xvi] racial health disparities are more severe in areas like the Lower Rio Grande Valley ("Valley").

Furthermore, Latinas have less access to affordable health insurance and healthcare if they live in a state that has not expanded Medicaid, severely impacting already medically underserved communities. In Texas, 50 percent of Latinas of reproductive age do not have health insurance[xvii] and many of these women will lose the opportunity to access reproductive healthcare because Texas has not expanded Medicaid.

Restrictions on abortion care have several, negative consequences for Latina health and well-being.

Measures that restrict access to abortion services further delay and increase the cost of abortion care for women. These policies create additional barriers to care for low-income, women of color, including Latinas, who rely on the federal government as their source of insurance coverage. This is especially true for women

who qualify and are enrolled in Medicaid because they are subject to the Hyde Amendment, which is a total ban on abortion coverage with limited exceptions for Medicaid enrollees. Because of this, many women who are making ends meet and who qualify for Medicaid are forced to continue with their pregnancies. Due to lack of Medicaid insurance coverage, between 18% and 35% of women who needed abortion care continued their pregnancies.[xviii] In states such as Texas, Latinas may pay an additional $146 dollars in seeking abortion care due to its 24 hour waiting period.[xix] Such restrictions on abortion care may put Latinas and their families in economic distress. In fact, studies show that women who need abortion services but are denied care are three times more likely to fall into poverty than those who are able to receive abortion care.[xx]

For immigrant Latinas, their immigration status dictates the healthcare they are able to receive. Restrictions on abortion care negatively impact their health and well-being by further limiting their options in accessing the full range of reproductive healthcare. Currently, undocumented Latinas and Deferred Action for Childhood Arrivals (DACA) recipients are barred from the tax credits and premium benefits of the Affordable Care Act, from using their own dollars to buy health insurance in the marketplaces, and are not eligible to apply for the Children's Health Insurance Program (CHIP) or Medicaid.[xxi] Additionally, Latinas who have been legal permanent residents for less than five years are also not eligible for Medicaid or CHIP.[xxii] Many immigrant Latinas may not have the necessary government identification to access affordable, healthcare services at clinics.[xxiii]

Also, immigrant Latinas face a lack of culturally and linguistically competent providers and lack of access to healthcare due to geography and lack of transportation. For many Latinas in the Valley in Texas who live in *colonias*, or unincorporated communities along the Texas-Mexico border, they may need to travel to a healthcare provider in cities, such as McAllen or Brownsville, which are several miles away. This is a real barrier given that these women face limited availability of public transportation or they must rely on private transportation to access the care they need. Making such arrangements has its own set of challenges, including taking time off of work, arranging and paying for childcare, saving money for gas, and waiting for friends and family to take them to their appointments.[xxiv] In our Nuestro Texas report, some Latinas underscored how transportation is a constant source of concern for them. A Latina from Mission, Texas, stated, "Sometimes it's a struggle, right, because [my husband] works and I don't drive. Most of the time we manage, but if he can't, then I just have to miss my appointment because we have no public transportation."[xxv] Because there are no local accessible clinics in Mission, this Latina and her family must travel to San Juan which is a half-hour drive away.[xxvi]

Sometimes, Latinas in the Valley are able to access preventive health tests, such as pap smears, at mobile clinics, but these clinics may only come to these women's

communities once a year.[xxvii] If these women cannot access affordable reproductive healthcare, they will often make the decision to travel to Mexico to access this care. For many, this is a difficult decision to make as they may not be able to return if they are undocumented.[xxviii]

Also, there are few sources of care for Latinas who need access to the full range of reproductive healthcare. Often, these restrictions impact providers who not only provide abortion care, but who also provide preventive healthcare, such as cervical cancer screenings, testing for sexually transmitted infections, and contraceptive care.[xxix] As one Latina commented in our Nuestro Texas report, "We have all the information we need on reproductive health but have no access and no money. What good is the information if we don't have help or access?"[xxx] Furthermore, for low-income Latinas who cannot access abortion care through Medicaid, they cannot seek this service at community health centers.[xxxi]

Finally, restrictions to the full range of pregnancy-related care may put Latinas at risk for unsafe abortion care, including care from unlicensed practitioners.

In addition, restrictions on abortion care are out of step for what most Latinos/as think regarding political interference in Latina decision-making. Seventy-four percent of registered Latino/a voters agree that a woman should be able to make her own personal, private decisions about abortion care without political interference.[xxxii]

Access to reproductive healthcare, including abortion care, is a pocketbook issue for many Latinas and their families. Restrictions on abortion care make it more likely that Latinas will have to decide between paying for the healthcare she needs or putting food on the table for her family.

Political and corporate interference in the personal, healthcare decisions of Latinas and their families contribute to poor health outcomes by denying them the ability to make the best decisions for their health with the consultation of their providers.

The Women's Health Protection Act can provide Latinas and other women of color one more tool in achieving positive, health outcomes and health equity. A woman's zip code should not determine the healthcare she receives or the health she wants to achieve.

NLIRH urges the committee to support the Women's Health Protection Act of 2013.

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Twenty-Five Faith-Based Organizations Express Support for the Women's Health Protection Act

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, DC 20510

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

As faith-based organizations that work to ensure every person in the United States has affordable access to safe and effective healthcare, including reproductive healthcare, we write to express our strong support for **S 1696, the "Women's Health Protection Act of 2013."**

Our faith traditions compel us to speak out for social justice and the right of every person to follow their own conscience in making decisions concerning their reproductive health and their families. We are committed to the most marginalized members of our society, especially those with limited financial means or those who live in areas without access to services. Laws that eliminate options for some based on their geographic location are profoundly unjust because they most harm low-income women, women of color and women in rural areas. We cannot in good conscience stand idly by as state laws transform our country into a map of haves and have-nots.

We believe that women are moral agents who have the capacity, right and responsibility to make their own reproductive decisions, no matter where they live, what their faith tradition or moral beliefs or how much money they have. Laws that result in limiting the availability of abortion disrespect women's human dignity; erode their constitutional rights; and can have far-reaching health and economic consequences for them and their families. Similarly, qualified medical professionals whose beliefs compel them to provide abortion care deserve protection for their conscience-based decisions to serve their communities.

We affirm that every woman has a right to religious liberty, which is integrally bound to her reproductive freedom. Religious liberty includes the right to follow one's own faith or moral code in making critical, personal reproductive health decisions and the right to be free from constraints imposed by others. While we respect the right of every individual, including our lawmakers, to hold their own personal and religious beliefs, our faith traditions and our country's constitution demand that no one should impose one religious viewpoint on all through civil law or regulation.

The **Women's Health Protection Act** is urgently needed. From 2011 through 2013, state legislatures enacted more laws restricting abortion access than in the entire preceding decade. This egregious trend has resulted in large swaths of the country losing access to safe, timely abortion care. This critical bill would protect at the federal level the right of every woman to make her own decisions about whether and when to have children, each led by her own conscience—without being stymied by her economic strata, employment status or zip code. It would invalidate state laws designed to restrict abortion access and make it more difficult to pass such laws in the future. And it would ensure that medical providers are able to care for patients who seek comprehensive reproductive healthcare.

Twenty-Five Faith-Based Organizations Express Support for the Women's Health Protection Act

Protecting safe, legal access to abortion is a moral imperative, rooted in our deeply held beliefs in social justice, moral agency and religious liberty. As people of faith, we value every person as a moral decision-maker who is free to make personal decisions about their reproductive lives based on their own consciences. The **Women's Health Protection Act** is critical legislation that embodies these shared ideals.

Today, and every day, we stand up as people of faith for women's health and reproductive choices. We thank you for calling a hearing on the **Women's Health Protection Act** and urge you and your colleagues to move this critical legislation forward. We ask this based on our diverse faith traditions, and because protecting the health and well-being of women and families is the right thing to do.

Respectfully,

A Critical Mass: Women Celebrating Eucharist
Bend the Arc: A Jewish Partnership for Justice
Catholics for Choice
Chicago Women-Church
Clergy Advocacy Board, Planned Parenthood Federation of America
CORPUS
Disciples Justice Action Network
Global Faith and Justice Project
Global Justice Institute
Hadassah, The Women's Zionist Organization of America
Jewish Women International
Keshet
Methodist Federation for Social Action
Metropolitan Community Churches
Muslims for Progressive Values
National Coalition of American Nuns
National Council of Jewish Women
Religious Coalition for Reproductive Choice
Religious Coalition for Reproductive Choice of Connecticut, Inc.
Religious Institute, Inc.
Society for Humanistic Judaism
United Church of Christ, Justice and Witness Ministries
Unitarian Universalist Women's Federation
Women's Alliance for Theology, Ethics, and Ritual
Women's Ordination Conference

For more information, please contact Amy Cotton at (202) 375-5067 or amy@ncjwdc.org, or Sara Hutchinson Ratcliffe at (202) 986-6093 or shutchinson@catholicsforchoice.org.

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

We, the undersigned state medical organizations representing physicians who care for women and their families every day, urge your support of the Women's Health Protection Act of 2013 (S. 1696/H.R. 3471).

For decades, politicians across the country have passed laws rolling back a woman's ability to make health care decisions for herself, by restricting access to safe, legal abortions. These laws and regulations severely hamper our ability to care for our patients in accordance with the most recent, evidence-based practice guidelines as well as our professional clinical judgment. In many states, the effect has been dire. Safe abortion care has become virtually impossible to find for far too many women. In fact, six states - Arkansas, Mississippi, Missouri, North Dakota, South Dakota, and Wyoming - currently only have one abortion clinic.

Our physician members work every day to make sure women receive the high-quality health care they need in a safe, respectful environment. State laws regulating the provision of abortion care in the name of women's health and safety frequently promote NEITHER health NOR safety.

Every woman must be able to make personal medical decisions -- without political interference -- according to her own unique circumstances. Similarly, physicians must be able to practice high quality medicine, without political interference.

Our patients and physicians can do neither when states:

- Require health care providers to perform tests and procedures on our patients that are not medically necessary;
- Require health care providers to practice according to outdated, rather than the best and most current, medical guidelines;
- Prohibit use of telemedicine advancements for abortion, technology that is especially important in underserved and rural areas;
- Impose medically unnecessary regulations on women's health centers that serve only to force clinics to close their doors;
- Require abortion providers to maintain admitting privileges at local hospitals, a business arrangement that only serves to reduce the number of providers, not to improve patient safety in any way. Complications are very rare and admitting privileges are not needed in the unlikely event that a patient needs hospital care;
- Require a woman to make multiple unnecessary trips to her abortion provider; and
- Require a woman to visit an anti-abortion "crisis pregnancy center" before her procedure.

Our organizations oppose these restrictions. They target abortion providers and women seeking abortion care with rules and limitations not imposed on any other clinicians or patients. And they're passed under the pretext of improving women's health, when in fact they don't reflect good medical practice or scientific evidence.

The Women's Health Protection Act will help protect women and their health from these politically-driven state efforts, and preserve our ability to deliver the best possible care to our patients. Medical care should not be dictated by geographic boundaries, and a woman's ability to obtain a safe and legal abortion should not depend on her zip code.

Sincerely,

California – District IX of ACOG

District of Columbia Section of ACOG

Florida – District XII of ACOG

Georgia Obstetrical and Gynecological Society

Georgia Section of ACOG

Hawaii, Guam & American Samoa Section of ACOG

Indiana Section of ACOG

Maryland Section of ACOG

Montana Section of ACOG

Nevada Section of ACOG

New Jersey Section of ACOG

New Mexico Section of ACOG

Ohio Section of ACOG

Pennsylvania Section of ACOG

Texas Section of ACOG

University of Utah OBGYN Residency Program

Virginia Section of ACOG

Washington Section of ACOG

Wisconsin Section of ACOG

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July 22, 2014

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Leahy and Ranking Member Grassley:

Physicians for Reproductive Health (Physicians) is a doctor-led national advocacy organization that uses evidence-based medicine to promote sound reproductive health policies. A large number of the doctors Physicians represents practice in the field of obstetrics and gynecology, but many are pediatricians, family physicians, cardiologists, neurologists, radiologists, and others. Physicians unites the medical community and concerned supporters. Together, we work to improve access to comprehensive reproductive health care, including contraception and abortion, especially to meet the health care needs of economically disadvantaged patients.

We write to follow up on the hearing held on July 15, 2014, on the Women's Health Protection Act of 2014 (S. 1696). This critical bill would ensure that all women are able to make personal decisions about reproductive health care, regardless of where they live. Abortion should not be singled out for politically motivated restrictions that threaten women's health. Below we share information about the safety of abortion, the importance of access to legal abortion, and the widespread acceptance within the medical community of both of these facts.

I. Safety of Abortion

When it is legal and accessible, abortion has an excellent safety record. Abortion is one of the safest medical procedures in the United States. At last week's hearing, several witnesses distorted statistics around the safety of abortion. Physicians would like to share correct information with the Judiciary Committee. For example, Representative Diane Black (R-TN) claimed that women that have an abortion are 18% more likely to develop breast cancer. The National Cancer Institute has found no link between abortion and an increased risk of breast cancer.[1] She also claimed that after an abortion, a woman is 81% more likely to develop a mental health issue, is at a 37% increased risk of depression, is at a 110% increased risk of alcohol abuse, and is at a 155% increased risk of suicide. These specious claims have similarly been debunked by national, reputable medical organizations, including the American Psychological Association.[2]

[1] Summary report: Early reproductive events and breast cancer workshop. Bethesda, MD: National Cancer Institute (2003). Available at http://www.cancer.gov/cancertopics/causes/ere/workshop-report.
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The risk of a major complication from first-trimester abortion, when 88% of abortions take place, is very small—less than 0.05%.[3] Abortions performed in the first trimester pose virtually no long-term risk of such problems as infertility, ectopic pregnancy, spontaneous abortion (miscarriage) or birth defect, and little or no risk of preterm or low-birth-weight deliveries.[4] The risk of death associated with legal, accessible abortion is 14 times less than the risk associated with continued pregnancy and delivery.[5] As the pregnancy advances, the medical risks with abortion increase from one death for every one million abortions at or before eight weeks to one per 29,000 at 16 to 20 weeks—and one per 11,000 at 21 weeks or later.[6] In comparison, the risk of death from continued pregnancy and delivery is approximately 8.8 per 100,000.[7] Given the gradual increase in risks with gestation for women seeking abortion, prompt access to abortion, free of politically motivated restrictions, is crucial for women's health.

Representative Black, Representative Marsha Blackburn (R-TN), and Chairman Grassley (R-IA) discussed the atrocious, criminal acts of Kermit Gosnell at length. Physicians, like the rest of the medical community, was horrified by this criminal's actions in Pennsylvania. He was flagrantly unethical and in breach of all accepted medical standards. It is important to note that Pennsylvania is a state that had multiple, medically unnecessary laws on the books that restrict women's access to abortion care. The lack of access to safe, compassionate care and the stigma surrounding abortion made it possible for Gosnell to prey upon women. Additional medically unnecessary restrictions on abortion will force more women to turn to immoral actors like Gosnell, as reputable clinics are forced to close.

II. Importance of Access to Abortion

Access to legal, safe abortion is critical to the health and well-being of women. The medical community has recognized this fact since before the U.S. Supreme Court's decision in *Roe v. Wade*, and indeed advocated for the decriminalization of abortion before *Roe* to protect women's health.[8] In 1972, 100 professors of obstetrics and gynecology published a letter to the medical and legal communities.[9] These 100 signers were national leaders in the field, most being chairs of departments at top medical schools. In September 2013, 100 new leading professors of obstetrics from across the United States came together to write a letter for the current generation of physicians caring for women. In response to the dangerously growing restrictions on safe abortion care, they wrote: "We have had 40 years of medical progress but have witnessed political regression that the [original] 100 professors did not anticipate."[10] They go on to describe the various restrictions at the state level that are impeding abortion access and note that they "will threaten, not improve, women's health and already obstruct physicians' evidence-based and patient-centered practices."[11] The 2013 letter is attached for the Committee's reference.

After a Texas law requiring hospital admitting privileges went into effect in November 2013, 19 of 33 abortion clinics closed, including clinics in McAllen. The closure of the McAllen clinic, located in the Rio

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[3] Weitz TA et al., Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver, *American Journal of Public Health*, 2013, 103(3):454–461.
[4] Id.
[5] Raymond EG and Grimes DA, The comparative safety of legal induced abortion and childbirth in the United States, *Obstetrics & Gynecology*, 2012, 119(2): 215–219.
[6] Bartlett LA et al., Risk factors for legal induced abortion-related mortality in the United States, *Obstetrics & Gynecology*, 2004, 103(4):729–737.
[7] Raymond, supra note 5.
[8] For example, ACOG submitted amicus briefs in both *Roe v. Wade* and *Doe v. Bolton* supporting abortion access.
[9] A statement on abortion by one hundred professors of obstetrics, *American Journal of Obstetrics and Gyneology* 1972, 112: 992-998, http://www.ajog.org/article/0002-9378%2872%2990826-5/pdf.
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[11] Id.

Grande Valley (one of the poorest regions in the nation), has forced women to make an estimated two-and-a-half hour (150 mile) drive to Corpus Christi, a four-hour (240 mile) drive to San Antonio, or a five-hour (310 mile) drive to Austin.[12] These distances can prove to be insurmountable obstacles for low-income women, leading some to seek more accessible but illegal abortion pills from Mexico.[13] The stark and established fact is that when abortion is less accessible, it becomes less safe. This current reality in Texas is unacceptable from a public health standpoint.

Legal abortion in the United States has improved women's health outcomes. From 1958-1967, at least 3,400 women died from abortion procedures, almost all of which were illegal.[14] For each death suffered from unsafe abortion, many other women had illegal abortions in circumstances that were degrading and led to dangerous complications. The number of deaths fell rapidly after abortion was legalized, as the medical community had predicted. We have long known that legal, accessible abortion means safe abortion. And we see this scenario play out internationally as well. According to the World Health Organization, one in eight maternal deaths (13%) is due to unsafe abortion.[15] Globally, the unsafe-abortion-related maternal death rate is some 350 times higher than the rate associated with legal induced abortions in the United States (0.6 per 100,000 abortions).[16] The World Health Organization observes that women are more likely to resort to unsafe abortion when abortion is restricted, unavailable, or inaccessible and that when it is highly restricted, abortions are mostly unsafe.[17]

III. Conclusion

Physicians for Reproductive Health is deeply concerned at the lack of access to safe, compassionate, legal abortion that is already occurring in parts of the United States, such as the Rio Grande Valley of Texas, where all clinics have closed, and Mississippi, where only one clinic remains open. We stand with medical professionals across the nation and from the past 40 years to reaffirm that women's health and dignity depends on ready, unimpeded access to abortion care. That is why we support the Women's Health Protection Act. We thank the Senate Judiciary Committee for holding a hearing on this important bill and for the opportunity to submit materials.

Sincerely,

Nancy Stanwood, MD, MPH
Board Chair, Physicians for Reproductive Health
Associate Professor of Obstetrics, Gynecology & Reproductive Sciences, Yale University School of Medicine

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[12] Manny Fernandez, Abortion Law Pushes Texas Clinics to Close Doors, THE NEW YORK TIMES, (March 6, 2014), http://www.nytimes.com/2014/03/07/us/citing-new-texas-rules-abortion-provider-is-shutting-last-clinics-in-2-regions.html?_r=0.
[13] Rick Jervis, Texas abortion law creates obstacles for Valley women, USA TODAY, (May 17, 2014), http://www.usatoday.com/story/news/nation/2014/05/17/texas-abortion-law-women-valley/8804871/.
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[16] Id.
[17] Id.

NATIONAL WOMEN'S HEALTH NETWORK
A VOICE FOR WOMEN, A NETWORK FOR CHANGE

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

July 13, 2014

Re: S.1696, The Women's Health Protection Act

Dear Chairman Leahy and Ranking Member Grassley,

I am writing on behalf of the National Women's Health Network, a nonprofit advocacy organization that works to improve the health of all women, to express our strong support for S. 1696, the Women's Health Protection Act of 2013.

The Network brings the voices of women consumers to policy and regulatory decision-making bodies. We are supported by our members and do not take financial contributions from drug companies, medical device manufacturers, insurance companies, or any other entity with a financial stake in women's health decision-making. The Network supports access to the full range of reproductive healthcare services, including abortion, no matter where a woman lives or how much money she makes. We promote the provision of evidence-based healthcare practices and information without restrictions driven by ideology.

For nearly 40 years, the Network has advocated for women's access to abortion and to safe and effective drugs and medical devices. Our long-time work in these two areas comes together in our defense of medical abortion – mifepristone is a safe and effective prescription medication approved to end a pregnancy. My testimony will focus on medication abortion restrictions in the states, which restrict everything from who can administer mifepristone to where and how it can be administered. Additionally, the Network strongly supports the full range of protections for abortion access that the Women's Health Protection Act would ensure.

Sincerely,

Cynthia A. Pearson
Executive Director
National Women's Health Network

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NATIONAL WOMEN'S HEALTH NETWORK
A VOICE FOR WOMEN, A NETWORK FOR CHANGE

Testimony for the Record

Submitted to the United States Senate Committee on the Judiciary

Hearing on S.1696, The Women's Health Protection Act: Removing Barriers to Constitutionally Protected Reproductive Rights

July 13, 2014

By Cynthia A. Pearson, Executive Director, National Women's Health Network

Dear Chairman Leahy, Ranking Member Grassley and members of the Committee,

The National Women's Health Network, a nonprofit advocacy organization that works to improve the health of all women, is pleased to submit written testimony to express our strong support for S. 1696, the Women's Health Protection Act of 2013.

The Network brings the voices of women consumers to policy and regulatory decision-making bodies. We are supported by our members and do not take financial contributions from drug companies, medical device manufacturers, insurance companies, or any other entity with a financial stake in women's health decision-making. The Network supports access to the full range of reproductive health services, including abortion, no matter where a woman lives or how much money she makes. We promote the provision of evidence-based healthcare practices and information without restrictions driven by ideology.

A woman's ability to access an abortion should not be determined by her zip code, yet that is exactly what is happening as more and more states introduce and pass harmful restrictions on healthcare providers and abortion services. These state legislative attacks target everything from when, where and how an abortion is performed to what is said and who says it. While some politicians claim that these restrictions are for women's safety, they actually endanger women's health by delaying services, requiring unnecessary procedures and shutting down clinics. In fact, abortion is very safe and well regulated and these state laws are singling out reproductive healthcare for onerous regulations that are not imposed in other areas of medicine. This proliferation of state restrictions in recent years has had the practical effect of making abortion inaccessible to many women across the country.

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For nearly 40 years, the Network has advocated for women's access to abortion and to safe and effective drugs and medical devices. Our long-time work on these two initiatives comes together in our defense of medical abortion – mifepristone is a safe and effective prescription medication approved to end a pregnancy. My testimony will focus on medication abortion restrictions, though the Network strongly supports the full range of protections for abortion access that the Women's Health Protection Act would ensure.

When personal healthcare decisions need to be made, people appreciate having options available, and abortion care is no different. Access to medication abortion provides women in the U.S. with the option to end a pregnancy safely, without a surgical procedure and offers the potential to expand access and allow a woman more alternatives about where her abortion will take place. However, many of these state attacks specifically target medication abortion and run the gamut from restricting who can administer the abortion pill to limiting where or how it can be provided to women. Superfluous regulations do not advance health and only serve to decrease access, increase cost and expose women to unnecessary potential harm.

In 38 states, mifepristone – the medication abortion pill – can only be provided by a physician. This restriction eliminates entire categories of health practitioners from being able to offer this medication to their patients, despite research showing that nurse-midwives, nurse practitioners and physician assistants can provide it to their patients safely and effectively. These laws both delay and decrease access to abortion care by unnecessarily limiting the type of clinician who can provide medication abortion.

In 12 states, mifepristone can only be provided in the physical presence of a physician. This restriction implies that speaking with a clinician via teleconference is inherently less safe than speaking in person prior to taking mifepristone. However, studies show that medication abortion with a doctor connected by teleconference is as safe and effective as a conventional office visit. Telemedicine abortion services can meet the health needs of women that would otherwise have to travel hundreds of miles to reach an abortion provider. These restrictions are not applied to other healthcare services that use telemedicine – they have nothing to do with the quality or safety of health care and everything to do with preventing a woman from getting abortion services.

Medication abortion restrictions that restrict who can administer mifepristone and where it can be administered only serve to decrease access to abortion care and disproportionately impact women that already have poor access to healthcare services such as low-income women, women of color, young women and women living in rural areas. The Women's Health Protection Act would ensure that medication abortion is not singled out for unnecessary additional regulations that even further limit women's access to the full range of healthcare providers and services.

When people seek out healthcare services they expect their clinician to provide safe, effective and evidence-based procedures and treatments. Unfortunately however, political interference in the practice of medicine at the state level means that women in some states can no longer expect this kind of high-quality healthcare. In Ohio, Texas and soon in Oklahoma, medication abortion must be provided in strict compliance with the protocol specified on the label, which was approved by the Food and Drug Administration nearly 15 years ago. Again, some politicians claim this is a safety regulation. However, the longer a drug is on the market, the more healthcare providers learn about it and they often use this additional information to make evidence-based changes to the original dose or directions for use. Consequently, requiring healthcare providers to use a 15-year-old protocol does not protect women's health.

This prohibition on what is known as "off-label use" is unnecessary and also potentially less safe for women seeking a medication abortion. The dose of mifepristone prescribed back in 2000 when the drug was first approved was three times the amount now commonly administered under the evidence-based practice followed by healthcare providers today. Also under the original protocol, women are not allowed to self-administer the follow-up dose, requiring them to complete the abortion at a clinic rather than in the comfort and privacy of their own home, even though studies have shown this to be safe. The Network strongly supports the Women's Health Protection Act because it would preserve women's access to this safe and effective option for early abortions.

The insidious harm done by opponents of abortion in attacking off-label use of mifepristone is that it makes people think abortion providers are acting differently than other clinicians. However, doctors in almost all areas of medicine prescribe medications off-label – in fact, 20 percent of all prescription drugs in the United States are used by physicians for purposes or doses that are not covered on the original label. For example, many cancer drugs are used off-label, as are most drugs prescribed to children. Laws that restrict how medication abortion can be provided set a dangerous precedent for political interference in the practice of medicine. Evidence-based health regulations ensure that healthcare is safe, effective and of high quality for all people and must be protected.

The restrictions on medication abortion described here are only part of the larger scale attacks on women's reproductive health and autonomy. State legislatures have passed burdensome requirements that single out abortion clinics, providers and services and do nothing to advance women's health or safety – and, in fact, ultimately jeopardize women's health by making abortion inaccessible to many women in this country. Each woman faces her own unique circumstances and much be able to make the decision that is best for her without interference from politicians. We thank you for calling a hearing on this vitally important legislation and strongly support passage of the Women's Health Protection Act.

The Honorable Patrick Leahy
437 Russell Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
135 Hart Senate Office Building
Washington, DC

July 16th, 2014

Dear Chairman Leahy and Ranking Member Grassley:

With more than 200 abortion restrictions passing in the states over the past 3 years[i], we agree that we must remove the onerous restrictions that have been placed on abortion providers and that obstruct women's health. Because of our commitment to reproductive health access, we applaud the Women's Health Protection Act (WHPA) of 2013 and support the removal of the many unnecessary and harmful restrictions that for too many put safe and timely abortion care out of reach. However, the WHPA's exclusion of parental consent and notification laws, which exist in 39 states[ii] and leave many young women afraid and alone, highlights the need to address parental involvement laws.

Young people are at the forefront of the reproductive rights, health, and justice movements. We need to stand with them against the harmful parental involvement restrictions that can put their health and well being at risk by removing restrictions placed on young women's ability to obtain abortion services. Parental involvement laws disproportionately impacts young people of color, who are more likely to experience unintended pregnancy as minors and are disproportionately living in states where parental involvement laws are in effect.[iii]

Parental involvement laws, including parental consent and parental notification laws, single out young people's access to abortion care. In many states, minors may independently consent to a range of sensitive health care services, including access to contraceptives, prenatal care, and STI care.[iv] This trend is based on the fact that young people are less likely to seek these sensitive services if they require parental involvement, especially when conditions at home are unsafe.[v] The American Medical Association, the Society for Adolescent Medicine, APHA, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and other health professional organizations stand in agreement against mandatory parental involvement in abortion decision making.[vi] Still, young women's access to abortion care requires parental consent or notification in a majority of states.

Ideally, any woman, including a young woman, who is faced with an unintended pregnancy can seek the advice of those who care for her. Studies show that most young women will seek support from a parent or family member when they find themselves with an unintended pregnancy. But for those who can't, those afraid to anger or disappoint, or who face the threat of violence in their homes— we believe it would be best for them to seek the advice of a trained medical professional than to face the situation alone and afraid.

The fact is that the majority of young people seeking abortions do consult a parent, no matter what state they live in.[vii] But those who are unable to involve their parents have good reasons. Fifty percent of pregnant teens have experienced violence;[viii] thirty percent of teens who don't tell their parents about their abortions fear the threat of violence or being forced to leave home.[ix] We all hope daughters and sons can turn to their parents when they make important decisions. But we cannot and should not legislate parent-child communication.

As an example, the unfortunate circumstances of a 16-year old young woman in Nebraska illustrate all too well the harmful impact of parental notification laws. Instead of her abortion being a private medical decision this young woman could make in consultation with her health care provider and those who support her, it was left in the hands of a judge who decided that at the age of sixteen, the young woman wasn't "mature" enough to decide for herself and denied her the abortion.[x] This judge decided to play politics with a young woman's life to advance his own extreme ideological agenda.

We hope that moving forward with this bill, and any other bill seeking to protect women's access to abortion, our legislators work to include younger women and protect their access to safe, legal, and affordable abortion care.

Sincerely,
Advocates for Youth

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[i] Guttmacher Institute. "State Legislation in 2011/2012/2013 Related to Reproductive Health." Accessed from http://www.guttmacher.org/statecenter/updates/2011newlaws.pdf, http://www.guttmacher.org/statecenter/updates/2012newlaws.pdf, http://www.guttmacher.org/statecenter/updates/2013Newlaws.pdf.

[ii] Guttmacher Institute. "State Policies in Brief: Parental Involvement in Minors' Abortions." Accessed from http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf.

[iii] Guttmacher Institute. "Confidential Reproductive Health Services for Minors: The Potential Impact of Mandated Parental Involvement in Contraception." Accessed from http://www.guttmacher.org/pubs/journals/3618204.pdf

[iv] Guttmacher Institute. "State Policies in Brief: Minors' Access to Contraceptive Services." Accessed from http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf.

[v] Dailard C and Richardson CT. "Teenagers' Access to Confidential Reproductive Health Care Services." *The Guttmacher Report on Public Policy*, 2005: 8(4).

[vi] American Medical Association. "Opinion 5.055 – Confidential Care for Minors." Accessed from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion5055.page on November 8, 2013. American Public Health Association. "Ensuring Minors' Access to Confidential Abortion Services." Accessed from http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1415 on November 8, 2013. American Academy of Pediatrics. "Achieving Quality Health Services for Adolescents." Accessed from http://pediatrics.aappublications.org/content/121/6/1263.full?sid=7322b383-0e96-4d24-a3ba-2914a99307bb on November 8, 2013. Center for Adolescent Medicine. *Policy Compendium on Confidential Health Care Services for Adolescents, 2nd Edition.* Accessed from http://www.cahl.org/PDFs/PolicyCompendium/PolicyCompendium.pdf.

[vii] Dennis A et al., The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review, New York: Guttmacher Institute, 2009

[viii] American Psychological Association, Parental Consent Laws for Adolescent Reproductive Health Care: What Does the Psychological Research Say? (Feb. 2000), citing A.B. Berenson, et al., Prevalence of Physical and Sexual Assault in Pregnant Adolescents, 13 J. of Adolescent Health 466-69 (1992).

[ix] Martin Donohoe, Parental Notification and Consent Laws for Teen Abortions: Overview and 2006 Ballot Measures MEDSCAPE Ob/Gyn & Women's Health, February 9, 2007

[x] Nebraska Supreme Court. *In Re Petition of Anonymous 5, a Minor.* Accessed from http://supremecourt.ne.gov/sites/supremecourt.ne.gov/files/sc/opinions/s13-510009.pdf.

National
Family Planning
& Reproductive Health Association

July 15, 2014

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
224 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary
152 Dirksen Senate Office Building
Washington, DC 20510

Re: **The Women's Health Protection Act (S. 1696)**

Dear Chairman Leahy and Ranking Member Grassley:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to submit this statement in support of the Women's Health Protection Act of 2013 (S.1696). By prohibiting state activity that impedes women's access to abortion services, the Women's Health Protection Act (WHPA) is designed to roll back the onslaught of state-level attacks on the legal right to have an abortion and on the clinicians who provide abortion services.

NFPRHA is a national membership organization representing the nation's family planning providers – nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of nearly 5,000 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private non-profit organizations.

As an advocate for providers, NFPRHA works to ensure that health professionals are able to offer a comprehensive range of sexual and reproductive health services, including abortion, to each patient based on their individual health needs. NFPRHA works to maintain access to and coverage for abortion services, while also promoting effective family planning, including contraceptive use, which helps to reduce unintended pregnancies.

Restrictive laws targeting abortion are frequently proposed under the guise of protecting women's health and increasing safety. However, the safety of abortion is well-documented[1] and the ultimate goal of these restrictions is to eliminate abortion in the United States entirely. A member of the board of Pro-Life Mississippi stated: "These incremental laws are part of a greater strategy to end abortion in our country. It's part of it, and one day, our country will be abortion free."[2] The reality is that these restrictions on abortion don't deter women from seeking out abortion care. Instead, restricting access to abortion just increases cost and potential risk by lengthening the time it takes for a woman to obtain the procedure once she's made her decision.[3] The strategy of limiting access as a means to a total ban on abortion has led to a proliferation of state restrictions on abortion services and providers. From 2011 to 2013, 30 states enacted 205 laws restricting abortion services and providers. In the ten years prior (2001-2010), a total of 189 state laws restricting abortion were passed.[4]

NFPRHA believes that in the face of unprecedented assault on women's health and rights in the states, it is past time to take a stand at the federal level. The Women's Health Protection Act would do just that, and would ensure that a woman's access to abortion is not dependent upon her zip code or income. The bill sets a baseline for women across the country that respects their decision-making and re-establishes the right for all women to make medical decisions in private consultation with her health care provider. In addition, the bill protects health care professionals committed to providing abortion services. Many of the more recent state-level restrictions on abortion services have targeted providers, leading to the closing of multiple sites across the country. Abortion providers deserve to be free of the targeted, discriminatory policies that have become all too common.

For all of these reasons, NFPRHA supports WHPA and thanks the Committee for calling a hearing on this bill.

Thank you for the opportunity to submit testimony on S. 1696. If you require additional information about the issues raised in this letter, please contact Mindy McGrath at 202-293-3114 ext. 206 or at mmcgrath@nfprha.org.

Sincerely,

Clare M. Coleman

Clare Coleman
President & CEO

[1] Guttmacher Institute, *Induced Abortion in the United States*, accessed 2014, http://www.guttmacher.org/pubs/fb_induced_abortion.html.

[2] Jeremy Alford and Erik Eckholm, "With New Bill, Abortion Limits Spread in South," *New York Times*, May 21, 2014, accessed July 10, 2014, http://www.nytimes.com/2014/05/22/us/politics/new-bill-spreads-abortion-limits-in-south.html?module=Search&mabReward=relbias%3Aw%2C%7B%222%22%3A%22RI%3A18%22%7D&_r=0.

[3] Jenna Jerman and Rachel K. Jones, "Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment," *Women's Health Issues* 24-4 (2014): e419-e424. http://www.guttmacher.org/pubs/journals/j.whi.2014.05.002.pdf

[4] Heather D. Boonstra and Elizabeth Nash, "A Surge of State Abortion Restrictions Puts Providers—and the Women They Serve—in the Crosshairs," *Guttmacher Policy Review* 17, no. 1 (Winter 2014), 9-15.

Hearing on S. 1696
Women's Health Protection Act (WHPA)
Senate Judiciary Committee

Testimony of
National Asian Pacific American Women's Forum (NAPAWF)

July 15, 2014

Dear Chairman Leahy and Ranking Member Grassley:

The National Asian Pacific American Women's Forum is writing to support the Women's Health Protection Act of 2013 (S.1696), which will protect critical access to reproductive health care for women of color including Asian American and Pacific Islander women.

The National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue organization devoted to advancing human rights for and increasing the power and impact of Asian American and Pacific Islander (AAPI) women and girls. We're changing policy, strengthening our communities and building the next generation of AAPI women leaders. Since our founding in 1996, we have 15 chapters across the country and 3 national offices. With over 19 million AAPIs in the United States, AAPIs are the fastest-growing racial group in the country.

NAPAWF seeks to achieve reproductive justice through advancing human rights for AAPI women and girls and increasing their influence, which will require that every AAPI woman has the resources and power she needs to make her own reproductive decisions. Stereotypes of AAPI women and girls, such as "model minority" stereotype, ignore the diverse needs and complexity of our communities. AAPI women and girls face barriers to reproductive health and justice, including racial inequity, economic status, language barriers, cultural stigma, sexual orientation, gender identity, and immigration status.

Access to reproductive healthcare has increasingly been under attack all across the nation, as evidenced by the Supreme Court's decision in *Burwell v. Hobby Lobby* and *McCullen v. Coakley*, and the growing number of abortion restrictions at the state level. Women of color and low income women are the most affected by these restrictions.

Under the Women's Health Protection Act (WHPA), states could no longer impose oppressive and medically unnecessary requirements on reproductive health care providers. In 2013 alone, more than 330 state lawmakers proposed 476 anti-abortion provisions.[1] Some of the restrictions include prohibiting insurance coverage for abortion services, restricting medication abortion, denying women and doctors the opportunity to use telemedicine, denying services to young abortion seekers, requiring extended waiting periods or mandatory ultrasounds, and trying to

[1] Lee, Jaeah, and Molly Redden, *Meet 330 Anti-abortion Lawmakers Who Made 2013 "a Terrible Year for Women's Health* MOTHER JONES. (Jan. 24 2014), http://www.motherjones.com/politics/2014/01/state-legislators-sponsored-abortion-restriction-2014.

regulate abortion clinics via unnecessary medical standards. These types of restrictions slowly chip away at abortion access and make comprehensive reproductive health care virtually impossible to obtain for many, especially low income women and women of color.

WHPA would also protect against abortion bans based on a woman's reasoning. As an AAPI women's organization, we are especially concerned about the passage of sex-selective abortion bans. This past year, sex selective abortion bans were the 2nd most proposed bill at state legislatures across the country.[2] These types of bills now exist in eight different states.[3]

Sex-selective abortion bans rely on racial stereotypes, increase stigma about AAPI women and girls, and undermine women's health. They hurt our communities and do nothing to help women. They are masked attempts to restrict abortion access and increase abortion stigma under the guise of ending gender discrimination. These types of bills exploit racial stereotypes that the AAPI community only prefers sons, causing AAPI women to face increased scrutiny around our motives for seeking abortion care. Threatening providers with criminal and civil penalties also has a chilling effect; it can mean that providers are less likely to serve members of the AAPI community. Proponents of the bill point to male biased sex-ratios in countries like China and India and claim that AAPI women are bringing sex-selective abortion to the United States and must be stopped. However, new research shows that in fact, AAPIs are having more girls overall than white Americans.[4]

Abortion access is critical for the health of AAPI women. AAPI women experienced increased unintended pregnancy and teen pregnancy over the past decade, and there is evidence to show women in our community are much less likely than others to use contraception. Moreover, national data reveals that 35 percent of pregnancies end in abortion for AAPI women, the second highest percentage for all racial/ethnic groups, compared to 18 percent for white women.[5] In spite of the need for accessible abortion care, there are gaps in services directed at AAPI women, who face language, financial, and cultural barriers to getting the care they need.

These restrictions are yet another barrier to AAPI women who already face significant health disparities and barriers to insurance access. AAPI women already have some of the highest rates of cervical cancer. Studies show that 24.1% of AAPI women have not had a pap test in the last three years.[6] Many AAPI women lack health coverage: 20.6% of AAPI women are uninsured.[7]

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[2] *Id.*

[3] ARIZ. REV. STAT. §§ 13-3603.02 (2013); 720 ILL. COMP. STAT. § 510/6-8 (2013); KAN. STAT. § 65-6726 (2013); N.C. GEN. STAT. § 90-21.121 (2013); N.D. CENT. CODE § 14-02.1-04.1 (2013); OKLA. STAT. TIT. 63 § 1-731.2 (2013); 18 PA. CONS. STAT. § 3204 (2013); H.B. 1162, 89th Leg., Reg. Sess. (S.D. 2014) (enacted);

[4] THE UNIVERSITY OF CHICAGO LAW SCHOOL INTERNATIONAL HUMAN RIGHTS CLINIC, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM and ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH, REPLACING MYTHS WITH FACTS: SEX-SELECTIVE ABORTION LAWS IN THE UNITED STATES (2014) *available at*: http://napawf.org/programs/reproductive-justice-2/sex-selection/race-and-sex-selective-abortion-bans/prenda/prenda-report/?key=52408357.

[5] Courtney Chappell, NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM, RECLAIMING CHOICE, BROADENING THE MOVEMENT: SEXUAL AND REPRODUCTIVE JUSTICE AND ASIAN PACIFIC AMERICAN WOMEN (2005), *available at* http://napawf.org/wp-content/uploads/2009/working/pdfs/NAPAWF_Reclaiming_Choice.pdf.

[6] THE HENRY J. KAISER FAMILY FOUNDATION, PUTTING WOMEN'S HEALTH CARE DISPARITIES ON THE MAP: EXAMINING RACIAL AND ETHNIC DISPARITIES AT THE STATE LEVEL, TABLE 2.7 (June 10, 2009), *available at* http://www.kff.org/minorityhealth/upload/7886.pdf.

[7] MARCH OF DIMES, CENSUS DATA ON UNINSURED WOMEN AND CHILDREN (2009) *available at*: http://www.marchofdimes.com/chapterassets/files/Uninsured_Highlights09.pdf

AAPI women do not need another obstacle in accessing health care. Making abortion harder to obtain will only exacerbate health outcomes for our community.

We believe the Women Health Protection Act is vital to protecting women's safe and legal access to reproductive healthcare, especially for women of color and low-income women. This bill provides necessary protections against xenophobic sex-selective abortion bans as well as other attacks on abortion access. Removing these barriers is critical to guaranteeing the constitutionally protected reproductive rights of AAPI women and other communities of color.

We ask that you support the Women's Health Protection Act of 2013 to make sure that all women, particularly AAPI women and women of color, have the ability to make decisions based on their own personal values, the advice of the medical professionals she trusts, and what's right for her family. Thank you for your time and attention to this important issue.

The National Asian Pacific American Women's Forum
Washington, DC

For any questions please contact Shivana Jorawar, Reproductive Justice Program Director, at sjorawar@napawf.org