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"Crossing the Line: Abortion Bans and Interstate Travel for Care After Dobbs"
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Questions for the Record

Senator Amy Klobuchar

Restrictions on abortion access are affecting women who must travel significant distances to obtain care. Given your expertise in reproductive health economics, could you discuss the economic impact on women and their families who need to travel for abortion care, including any data on the financial burdens and employment consequences they might encounter? What are some surprising or unexpected costs facing patients who seek this care?

Access to abortion in the U.S. has long been inequitable, but the *Dobbs* decision has fractured the landscape even further. From 2020 to 2023, the proportion of abortion patients who traveled out-of-state increased substantially from 9% to 17%.[1] In the months since, the need for travel has only increased, with Florida passing a six-week ban. Patients who are forced to travel outside of their communities for care, especially those traveling out-of-state, face substantial financial barriers.

In addition to the cost of the procedure itself—which too often must be paid out-of-pocket[2] because of discriminatory restrictions on abortion coverage—patients must foot the bill for transportation and lodging.[3] Many patients must also pay for costs such as childcare, since most abortion patients in the U.S. are already parents, and patients may lose wages from taking time off from work to travel. These costs are particularly harmful for individuals forced to travel: abortion patients living in states with restricted access to care are more likely, when compared to those in states with access, to rely on financial assistance and more likely to report difficulty paying for their care.[4]

These financial and logistical obstacles can be insurmountable for those struggling to make ends meet, and other communities that face the greatest barriers to abortion access, including young

[1] Abortion in the United States, Guttmacher Institute, June 2024. https://www.guttmacher.org/fact-sheet/induced-abortion-united-states
[2] Jones RK, Medicaid's role in alleviating some of the financial burden of abortion: findings from the 2021–2022 Abortion Patient Survey, Perspectives on Sexual and Reproductive Health, 2024, https://doi.org/10.1111/psrh.12250.
[3] Jones, Rachel K., Ushma D. Upadhyay, and Tracy A. Weitz. "At what cost? Payment for abortion care by US women." Women's Health Issues 23.3 (2013): e173-e178.
[4] Rachel Jones and Doris Chu. 2023. "Characteristics of abortion patients in protected and restricted states accessing clinic-based care 12 months prior to the elimination of the federal constitutional right to abortion in the United States." Perspectives on Sexual and Reproductive Health 55(2).

people, people with disabilities, and immigrants. For individuals who are unable to receive wanted abortion care, there are additional economic impacts. The ability to make and carry out decisions about one's reproductive life is inextricably linked to economic outcomes and financial stability, and this is reflected in the evidence base. Women who were denied wanted abortion care, compared to those who received abortions, experienced negative financial impacts, including increased debt and adverse events such as evictions[5] and an increased likelihood of falling below the federal poverty level.[6]

Abortion funds and practical support networks are doing incredible work to make abortion access a reality for many patients that would otherwise find the care and logistics of travel unaffordable—but it is work that should not be required. Every individual deserves affordable abortion care in their own community, and no person should have to travel for basic health care. As long as abortion patients are forced to travel for care, economic burdens on patients will continue, and not all patients will be able to overcome these hurdles to obtain their care.

Senator Mazie Hirono

1. **As a data scientist at the Guttmacher Institute, you have studied the actual impact of the *Dobbs* decision through data collection over the last two years. What does the research tell us about how the overturning of *Roe* has affected the wellbeing of women in the U.S.?**

There is clear and growing evidence that *Dobbs* is harming reproductive health and freedom. An increasingly robust body of evidence is emerging that illustrates the myriad harms caused and exacerbated by the Supreme Court decision to overturn *Roe*. [7] We know that when people aren't able to access health care (and in this case, when those who could become pregnant experience fear and stress that they may not be able to access the full range of reproductive services they may need) it impacts their wellbeing.

Further, evidence suggests the *Dobbs* decision has worsened access to health care more broadly. Some research suggests that access to contraceptive care is worsening in a post-*Dobbs* era; OB-GYNs, residents and medical students are under stress and leaving hostile states; there is the potential erosion of people's mental health; and there are potential risks for maternal health. All of these impacts – and more – fall hardest on communities already marginalized within the health care system, including Black and other people of color, young people, immigrants, LGBTQ folks, disabled people and those with low incomes.

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[5] Sarah Miller et al. 2023. "The Economic Consequences of Being Denied an Abortion." American Economic Journal: Economic Policy, 15 (1): 394-437.

[6] Foster DG, Biggs MA, Ralph L, Gerdts C, Roberts S, Glymour MM. "Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States." Am J Public Health. 2018 Mar;108(3):407-413.

[7] Baden K, Dreweke J, and Gibson C. "Clear and Growing Evidence That Dobbs Is Harming Reproductive Health and Freedom." Guttmacher Institute. May 2024. https://www.guttmacher.org/2024/05/clear-and-growing-evidence-dobbs-harming-reproductive-health-and-freedom

We also acknowledge that our understanding remains incomplete and that the full scope of harms to people's wellbeing caused by the ruling may not be clear for years to come. However, the evidence suggests that it will not be easy to repair the devastation caused by the *Dobbs* decision.

2. **During the hearing, one of my colleagues posed a hypothetical of a pregnant woman at the 34th week of pregnancy deciding, for emotional reasons, that she no longer wants a baby and would rather have an abortion. After being told that this rarely happens, my colleague responded, "you don't know that" and stated that his hypothetical "was not unrealistic." What research supports the assertion that hypotheticals like these do not reflect the reality of abortion in this country?**

Every pregnancy is unique. There are many reasons people may seek abortion care throughout their pregnancy, though rarely is it a flippant decision as suggested in the question from Sen Kennedy. For abortions that take place at 21 weeks or later, it may be that the pregnant person learns of a devasting diagnosis or otherwise experiences a severe medical circumstance; although data is limited, this is likely much more common for pregnancy terminations in the third trimester. Another common reason a person may have an abortion after 20 weeks in pregnancy is due to logistical delays in accessing care, which is especially relevant in states with abortion bans and restrictions.[8] Other reasons include domestic violence, changes in life circumstances, already raising other children, mental health challenges, not learning of the pregnancy until later, and more. In any case, the pregnant person in consultation with her health care provider, is best equipped to make a decision about the pregnancy; there is never a role for government and politicians to make that decision.

3. **Can you tell us if any states or localities have tried to ban travel for abortion care, and whether those restrictions target the person seeking care, minors seeking abortion care, and/or those who are supporting and helping people travel to seek abortion care?**

There is a targeted effort by anti-abortion activists and politicians to restrict people's travel for abortion care. For example, Tennessee passed a bill this year that prohibits an adult (who is not the parent) from assisting an individual younger than 18 in obtaining an abortion, including transporting the pregnant person to get an abortion. In 2023, Idaho passed a law that makes it a crime to support a person younger than 18 in accessing an abortion, including transporting the young person for care, with the intent to conceal the abortion from the young person's parent or guardian. The Idaho law is currently blocked, and both laws are being challenged in court. In their 2024 state legislative sessions, Alabama, Mississippi and Oklahoma also introduced similar bills. While these laws focus on minors' access, it has been a common tactic of anti-abortion advocates to start by putting restrictions on minors, and then work to expand those same restrictions to all people. Furthermore, adolescents are experts in their own lives and deserve the full range of information, resources and access to reproductive health care, including abortion, without the threat that someone who is supporting them will be criminalized.

[8] Foster, D.G. and Kimport, K. (2013), Who Seeks Abortions at or After 20 Weeks?. Perspect Sex Repro H, 45: 210-218. https://doi.org/10.1363/4521013

Attempts to ban travel for abortion care are more common at the local level, especially in Texas, where city councils and county boards have debated and sometimes passed bans on travel for abortion care. For example, localities in Texas that have passed ordinances prohibiting travel[9] through their jurisdictions for seeking abortion care out of state include Athens, Abilene, Plainview, San Angelo, Odessa, Muenster and Littler River-Academy, as well as Lubbock, Cochran, Mitchell, Goliad, Jack and Dawson Counties. Localities outside Texas are also starting to see such ordinances being debated.

a. **Whether those policies are enacted to not, can you speak to the impact they have on people seeking abortion even by the fact of being introduced and debated publicly?**

What these travel bans really aim to do is scare people into not getting the care they need and to scare the helpers. Travel bans are unconstitutional and they may not be enforceable, but they are intended to have a chilling effect, which makes these efforts so harmful and stigmatizing.

Senator John Kennedy

1. **During the hearing, Jocelyn Frye acknowledged that "1 percent of abortions happen at 21 weeks or later." In raw numbers, approximately how many abortions happen in the United States each year at or after 21 weeks of gestation?**

According to CDC data, less than 1% of abortions happen at 21 weeks or later[10], and this proportion gets much smaller at later gestational durations. The most recent year for which we have both CDC data on gestational duration and comprehensive abortion counts for the United States is 2020, when there were an estimated 930,160 abortions at any gestational duration[11]; this implies approximately 9,000 abortions at gestational durations 21 weeks or later.

2. **During the hearing, Jocelyn Frye testified that "the vast majority of pregnancies and abortions that are considered late in a pregnancy have to do with severe, devastating medical circumstances." Is this an accurate statement? Please explain.**

Every pregnancy is unique. There are many reasons people may seek abortion care throughout their pregnancy. Certainly, many abortions take place after the pregnant person learns of a devasting diagnosis or otherwise experiences a severe medical circumstance. Another common reason a person may have an abortion after 20 weeks in pregnancy is due to logistical delays in accessing care; which is especially relevant in states with abortion bans and restrictions. Other reasons include domestic violence, changes in life circumstances, mental health challenges, not learning of the pregnancy until later, and more. In any case, the pregnant person in consultation

[9] Lozano Carver, Jayme and Salinas II, Juan, "Amarillo City Council rejects so-called abortion travel ban," The Texas Tribune, June 2024. https://www.texastribune.org/2024/06/11/amarillo-city-council-abortion-travel-ban/
[10] Kortsmit, Katherine. "Abortion surveillance—United States, 2020." MMWR. Surveillance Summaries 71 (2022).
[11] Maddow-Zimet I and Gibson C, Despite bans, number of abortions in the United States increased in 2023, Policy Analysis, New York: Guttmacher Institute, 2024, https://www.guttmacher.org/article/2022/06/long-term-decline-us-abortions-reverses-showing-rising-need-abortion-supreme-court

with her health care provider is best equipped to make a decision about the pregnancy; there is a never a role for government and politicians to make that decision.

3. **A study published in 2013 examined the reasons women seek abortions after 20 weeks and observes that the "data suggest most women seeking later terminations are not doing so for reasons of fetal anomaly or life endangerments." D. Foster & K. Kimport, *Who Seeks Abortions at or After 20 Weeks?*, Perspectives on Sexual and Reproductive Health (2013, Vol. 45, Issue 3). Do you disagree? If so, why?**

This is an inaccurate interpretation of the findings from this study, which excluded the specific population of people seeking abortions on grounds of fetal anomaly or life endangerment (from that same article: "Our data are limited by the exclusion of women who sought later abortions on grounds of fetal anomaly or life endangerment"). In addition, the specific sentence cited in your question was the subject of a corrigendum by the authors in 2019; that corrigendum[12] is pasted below in full, but makes clear that the study is unable to speak to abortions occurring in the third trimester of pregnancy.

"One sentence on page 210 in the introduction of the article has been misinterpreted. We say "data suggest that most women seeking later terminations are not doing so for reasons of fetal anomaly or life endangerment." The sentence is about abortions performed from 20 weeks to the end of the second trimester, and it has no relevance to abortions in the third trimester. Only about one percent of abortions occur in the second half of pregnancy (at or beyond 20 weeks) and the vast majority of these occur close to 20 weeks. Our article, which focuses on women seeking abortions from 20 weeks to the end of the second trimester (about 28 weeks), therefore captures most of the women having abortions after 20 weeks. Little is known about the relatively few abortions occurring in the third trimester, although late detection of fetal anomaly and increasing incidence of maternal health complications with advanced gestation suggest that reasons for abortion in the third trimester may differ from those in the second."

4. **When estimating the number of abortions performed in the United States each year, what is the Guttmacher Institute's methodology for capturing or estimating the number of individuals who access abortion pills from unofficial online sources?**

Guttmacher's Monthly Abortion Provision Study estimates the number of clinician-provided abortions provided in each US state without a total ban for each month since January 2023. You can see our methodology here.

5. **The Guttmacher Institute says that the "federal government should assist states that currently have no abortion surveillance systems to create them and help some of those that already have systems in place to collect better data and release them in a more timely manner." J. Dreweke, *Abortion Reporting: Promoting Public Health, Not Politics*, Perspectives on Sexual and Reproductive Health (June 2015, Vol. 18,**

[12] (2019), Corrigendum. Perspect Sex Repro H, 51: 185-185. https://doi.org/10.1363/psrh.12114

Issue 2). Does the Guttmacher Institute support a federal effort to improve state-level abortion reporting systems?

Data collection by health departments on abortion can sometimes be useful for public health purposes; as the article you cite notes, however, this reporting has often been used to politicized ends and in ways that can be "highly intrusive into patient privacy and can risk patient confidentiality." The risks and burdens of mandated reporting of individual-level records have gotten even greater post-*Dobbs*, where provider caseloads have increased substantially and both patients and providers have warranted privacy concerns. Consequently, Guttmacher does not support mandated reporting of individual-level abortion data, which can be burdensome and intrusive and out of line with how data is collected for similar medical procedures.

6. **It is well understood that "gaps in state abortion surveillance have hampered efforts by the CDC to compile complete abortion statistics at the national level." J. Dreweke, *Abortion Reporting: Promoting Public Health, Not Politics*, Perspectives on Sexual and Reproductive Health (June 2015, Vol. 18, Issue 2). Does the Guttmacher Institute believe that states should be required to report abortion statistics to the Centers for Disease Control and Prevention?**

No.

7. **The Guttmacher Institute has said that abortion reporting is "an important public health tool" and that the "incidence of induced abortion is an important public health indicator." J. Dreweke, *Abortion Reporting: Promoting Public Health, Not Politics*, Perspectives on Sexual and Reproductive Health (June 2015, Vol. 18, Issue 2). But some states, including California, do not report abortion statistics to the Centers for Disease Control and Prevention or collect this data at all.**

    a. **Does the Guttmacher Institute believe that California (and similarly situated states) should collect abortion statistics?**

Data collection by health departments on abortion can sometimes be useful for public health purposes; as the article you cite notes, however, this reporting has often been used to politicized ends and in ways that can be "highly intrusive into patient privacy and can risk patient confidentiality." The risks and burdens of mandated reporting of individual-level records have gotten even greater post-*Dobbs*, where provider caseloads have increased substantially and both patients and providers have warranted privacy concerns. Consequently, Guttmacher does not support mandated reporting of individual-level abortion data, which can be burdensome and intrusive and out of line with how data is collected for similar medical procedures.

    b. **Does the Guttmacher Institute believe that California (and similarly situated states) should publicly report its data on abortion statistics?**

Data collection by health departments on abortion can sometimes be useful for public health purposes; as the article you cite notes, however, this reporting has often been used to politicized ends and in ways that can be "highly intrusive into patient privacy and can risk patient confidentiality." The risks and burdens of mandated reporting of individual-level records have gotten even greater post-*Dobbs*, where provider caseloads have increased substantially and both patients and providers have warranted privacy concerns. Consequently, Guttmacher does not support mandated reporting of individual-level abortion data, which can be burdensome and intrusive and out of line with how data is collected for similar medical procedures.