Statement for the Record

Of

The American College of Obstetricians and Gynecologists

Before the

House Committee on Oversight and Reform

Regarding the Hearing

"A State of Crisis: Examining the Urgent Need to Protect and Expand Abortion Rights and Access"

September 30, 2021

Chair Maloney, Ranking Member Comer, and distinguished members of the House Committee on Oversight and Reform, thank you for the opportunity to submit this statement for the Committee's record of its hearing titled "A State of Crisis: Examining the Urgent Need to Protect and Expand Abortion Rights and Access."

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women and is the premier membership organization for obstetrician-gynecologists. With more than 62,000 members, ACOG advocates for quality health care, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG thanks the Committee for examining the impacts of government restrictions on abortion, including Texas Senate Bill 8, which are politically motived, have no basis in medical evidence, put health care services out of reach for many individuals, and intrude upon the patient-physician relationship.

ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care. Policy related to reproductive health care must be based on medical science and facts. The government can serve a valuable role in making health policy when its purpose is to improve patient health and advance medical and scientific progress.[1]

Abortion is an essential component of health care.[2] Like all medical matters, decisions regarding reproductive health care, including abortion care, should be made by patients in consultation with their clinicians and without undue interference by outside parties.[3] Like all patients, individuals seeking abortion are entitled to privacy, dignity, respect, and support.[4]

The Committee's hearing today could not come at a more pivotal time. Abortion, although still legal, is increasingly out of reach because of mounting government-imposed restrictions targeting patients, physicians, and other clinicians, and recent years have seen a dramatic increase in the number and scope of legislative measures restricting abortion.[5] This mosaic of state laws and regulations has escalated access inequities and threatens to criminalize or otherwise penalize physicians and other clinicians for providing care consistent with their medical judgment, standards of care, and their patients' needs. It cannot be overstated that the patients disproportionately harmed are people of color, those who must travel long distances to receive care such as those living in rural or other underserved areas, and individuals with low incomes. We commend the Chair for inviting witnesses to participate in the hearing who can shed light on the lived experiences of these individuals and the role that state restrictions have in indefensibly limiting their access to care. ACOG urges the Committee to generate dialogue informed by science and medical facts and guided by Congress's imperative to confront health inequities. We find ourselves in a moment that demands urgent scrutiny and swift action by Congress.

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[1] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship (reaffirmed August 2021)

[2] *Abortion Policy Statement*, The American College of Obstetricians and Gynecologists, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/abortion-policy (Reaffirmed Nov. 2020)

[3] *Id.*

[4] *Id.*

[5] *Increasing access to abortion.* ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e107–15.

This statement reviews the clinical facts regarding the provision of abortion care and gives voice to the physicians—ACOG's members—who every day face the real-world implications of political intrusions in patient care.

Texas Senate Bill 8

ACOG shares the Chair's alarm over Texas Senate Bill 8 (SB8), which represents a clear attack on the practice of medicine, impermissibly intrudes into the patient-physician relationship, and restricts patients from making personal decisions about their health. By allowing third-party lawsuits against clinicians, by virtually banning all abortions, and by curtailing the sharing of information and support related to access to vital women's health care, SB8 creates a coercive environment for patients and clinicians across the spectrum of care and from all corners of the state.

SB8 is fundamentally at odds with the provision of safe and essential health care and longstanding principles of medical ethics. It places clinicians in the untenable position of choosing between providing care consistent with their best medical judgment, scientific evidence, and the clinicians' ethical obligations or risking legal retribution. It interferes with the patient-physician relationship and has the potential to pose grave dangers to patient well-being.

In the weeks since SB8 took effect, we are hearing alarm from our members in Texas. Physicians are concerned that an open, compassionate, and evidence-based conversation in the exam room now exposes them to legal action. They are unsure what life-threatening conditions qualify under a narrow medical emergency exception, and they are being forced to choose between following the law and doing what is best for their patients' health.

SB8 dangerously limits the ability of pregnant individuals at or beyond six weeks' gestation to obtain the health care they need. Only those with abundant financial resources will be able to travel outside of Texas to obtain an abortion. Others will be forced to seek abortion outside of the health care system or carry a pregnancy to term, increasing the likelihood of negative consequences to their physical and psychological health that could be avoided if care were available.[6]

SB8 causes particularly severe harm to patients of color, those with limited socioeconomic means, and those in rural communities. This is because, as a general matter, 75 percent of those seeking abortion are living at or below 200 percent of the federal poverty level, and the majority of patients seeking abortions identify as Black, Hispanic, Asian, or Pacific Islander.[7] Similarly, traveling out of state for medical care is more difficult, if not impossible, for patients with limited means or geographic remoteness.

Further, because more than 45 percent of pregnancies in the United States are unplanned, and because many medical conditions—including irregular periods—may mask a pregnancy, many women do not discover they are pregnant for several weeks, and may be likely to miss the six week window during which they can legally access an abortion in Texas.[8,9] It often takes time before patients who have decided they need to end their pregnancy to access abortion care given the host of logistical and financial barriers

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[6] *Increasing access to abortion.* ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e107–15.
[7] Jerman J, Jones RK and Onda T, Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014.
[8] *Unintended Pregnancy in the United States.* Fact Sheet. Guttmacher Institute. January 2019. Available at https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states
[9] Upadhyay UD, Weitz TA, Jones RK, Barar RE, Foster DG. Denial of abortion because of provider gestational age limits in the United States. Am J Public Health. 2014;104(9):1687-1694. doi:10.2105/AJPH.2013.301378

many face, including paying for the procedure, and organizing transportation, accommodation, childcare, and time off from work. One recent study found that women receiving first-trimester abortions were delayed in doing so for a variety of reasons: 36.5 percent due to travel and procedure costs, 37.8 percent due to not recognizing the pregnancy, 20.3 percent due to insurance problems, and 19.9 percent due to not knowing where to find abortion care.[10]

The "medical emergency" exception under SB8 does not mitigate the law's grave dangers. This exception is drawn so narrowly that it prevents abortions even when necessary to avoid grave risks to a patient's health unless that patient is in imminent risk of death or irreversible morbidity. At six weeks' gestation, potentially life-threatening conditions may not yet have manifested or a recommended course of treatment may not yet be evident. It is untenable to force a pregnant patient to wait until their medical condition escalates to the point that "an abortion is necessary to preserve [their] life" or their pregnancy creates "serious risk of substantial and irreversible impairment of a major bodily function" before being able to seek potentially life-saving care. Nor should physicians be put in the impossible position of either waiting for a patient's health to deteriorate or face legal retribution for performing an abortion in contravention of the law.

It is impossible to fully illustrate in this testimony the extent to which SB8 causes severe harm to our members and their patients. SB8 undermines patient autonomy, interferes in the patient-physician relationship, and prevents physicians from providing safe, evidence-based care.[11] It has been condemned by clinicians across the medical specialty spectrum, from primary care to hematologists to our colleagues in oncology.[12,13] As long as SB8 remains in effect, the practice of medicine is imperiled in Texas. Meanwhile, lawmakers in other states have suggested they may try to enact their own versions of SB8. In this environment, we implore the Committee and Congress to act with urgency to codify the rights of our patients to access comprehensive health care and the rights of physicians to practice evidence-based medicine free of government intrusion.

Clinical Guidance and Medical Research Regarding Reproductive Health Care

ACOG issues evidence-based clinical practice guidelines and has developed evidence-based statements of policy on reproductive health care through a thorough, deliberative, collaborative process among leading experts in the field of women's health. Pertinent today for the Committee's consideration is our robust body of clinical guidance that spans information regarding the medical management of first trimester abortion that can be accomplished through medication[14], abortion training and education[15], abortion

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[10] *Denial of Abortion Because of Provider Gestational Age Limits in the United States.* Udapdhyay et al., 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014).

[11] Global Women's Health and Rights. American College of Obstetricians and Gynecologists. Statement of Policy (reaffirmed July 2021). Available at https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2018/global-womens-health-and-rights

[12] Leading Physician Groups Oppose Texas Legislation That Threatens Access to Reproductive Patient Care (Sept. 2, 2021). Available at https://www.acog.org/news/news-releases/2021/09/physician-groups-oppose-texas-legislation-threatening-access-to-reproductive-patient-care

[13] American Medical Association statement on Texas SB8 (Sept. 1, 2021). Available at https://www.ama-assn.org/press-center/ama-statements/ama-statement-texas-sb8

[14] *Medication abortion up to 70 days of gestation.* ACOG Practice Bulletin No. 225. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e31–47.

[15] *Abortion training and education*. Committee Opinion No. 612. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1055–9.

access[16], and clinical management of second trimester abortion procedures.[17]

Abortion is extremely safe. It has complication rates that are lower than other routine medical procedures and its complication rates are substantially lower than childbirth.[18] In the United States, over 92 percent of abortions occur within the first trimester, when abortion is safest.[19] Serious complications from abortions at all gestational ages are rare. Advances in medical science have expanded safe options for pregnancy termination. For example, medical abortion, which involves the use of medications rather than a procedure to induce an abortion, is a safe, effective option for individuals who seek termination of a first-trimester pregnancy.[20]

Notwithstanding the safety of abortion, the provision of abortion is highly regulated in many states. Particularly relevant to the hearing topic today is ACOG's Committee Opinion 815, Increasing Access to Abortion, clinical guidance that examines the impact that restrictions on abortion access have on women's health.[21] The Committee Opinion highlights certain factors that may influence or necessitate a person's decision to have an abortion. These factors include but are not limited to contraceptive failure, barriers to contraceptive use and access, rape, incest, intimate partner violence, fetal anomalies, illness during pregnancy, and exposure to teratogenic medications. Pregnancy complications, including placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, and cardiac or renal conditions, may be so severe that abortion is the only measure to preserve a woman's health or save her life. All terminations are considered medically indicated.[22]

ACOG's Committee Opinion 815 further considers the substantial damage abortion restrictions may impose on health care, stating that legislative restrictions fundamentally interfere with the patient-clinician relationship and decrease access to abortion, particularly for individuals with low incomes, adolescents, people of color, people experiencing incarceration, and those living long distances from health care services.[23] The Committee Opinion calls for advocacy to oppose and overturn restrictions, improve access, and mainstream abortion as an integral component of women's health care. Government restrictions "marginalize abortion services from routine clinical care," the Committee Opinion concludes, and "are harmful to people's health and well-being." This conclusion is consistent with a study published by the National Academies of Medicine, Engineering, and Science that the greatest threats to the safety and quality of abortion in the United States are unnecessary government regulations on abortion.[24] In its assessment, the report cited that these threats impact all six attributes of health care quality: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.[25]

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[16] *Increasing access to abortion.* ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e107–15.
[17] *Second-trimester abortion*. Practice Bulletin No. 135. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:1394—1406.
[18] National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* (2018) ("Safety and Quality of Abortion Care"); *see also* Raymond & Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, 119 Obstetrics & Gynecology 215, 216 (2012).
[19] Kortsmit K, Jatlaoui T, Mandel M, et al. Abortion Surveillance—United States, 2018. MMWR Morb Mortal Wkly Surveillance Summaries. Nov. 27 2020;69(7);1-29.
[20] *Medication abortion up to 70 days of gestation.* ACOG Practice Bulletin No. 225. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e31–47.
[21] *Increasing access to abortion.* ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e107–15.
[22] *Id*.
[23] *Id.*
[24] *The Safety and Quality of Abortion Care in the United States.* National Academies of Sciences, Engineering, and Medicine. (March 2018). Available at https://www.nap.edu/read/24950/chapter/1
[25] *Id*.

Moreover, ACOG, along with representatives from the National Partnership for Women & Families, American College of Physicians, American Academy of Family Physicians, American College of Nurse-Midwives, Nurse Practitioners in Women's Health, and the Society of Family Planning recently led a rigorous review of the available evidence and guidelines that inform safe delivery of outpatient care.[26] The objective of this study was to inform policy regarding the provision of procedures in primary care, including the field of obstetrics and gynecology, in order to further health care quality, safety, affordability, and patient experience without imposing unjustified burdens on patients' access to care or on clinicians' ability to provide care within their scope of practice. In the published findings, the authors note that in policy and law, regulation of abortion is frequently treated differently from other health services.[27] They affirm that the safety of abortion is similar to that of other types of office- and clinic-based procedures, and any facility requirements should be based on assuring high quality, safe performance of all such procedures, but conclude that false concerns for patient safety are being used as a justification for promoting regulations that specifically target abortion.

As you consider today's testimony, we urge your discourse and questioning to be informed by this evidence-based research and guidance.

The Importance of Using Medically Accurate Terminology and Information

Public and political discourse regarding abortion is too often inaccurate and not based on medical science. False claims undermine the public's trust in obstetrician-gynecologists and stigmatize necessary health care. We urge members of the Committee today to be aware that medically inaccurate and inflammatory language can contribute to or encourage hostility or violence toward physicians, other medical professionals, or individuals seeking or receiving basic health care services.

ACOG also seeks to correct false claims that have been made in the public discourse that abortion is never medically necessary. This is a dangerous narrative, which ACOG appreciates the opportunity to clarify for the Committee. Pregnancy imposes significant physiological changes on a person's body. These changes can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health or even cause death. Our members are focused on protecting the health and lives of their patients, and determining the appropriate medical intervention based on a patient's specific condition, without unjustified government mandates, is critical to their ability to provide quality care. This includes situations where abortion is the only medical intervention that can preserve a patient's health or save their life.[28]

When discussing policy related to health care, terminology is critically important. Patient care should never be legislated on false or inaccurate premises. One example found in many policy contexts is the deployment of the term "heartbeat" to impose arbitrary abortion bans that are not reflective of clinical fact. While contemporary ultrasound can detect an electrically induced flickering of a portion of the embryonic tissue at about six weeks gestation, structurally and in function, a fetus' heart develops over the entire course of pregnancy and does not complete development or function fully until after delivery.[29]

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[26] *Report from the project on facility guidelines for the safe performance of primary care and gynecology procedures in offices and clinics*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:255–60.

[27] *Id*.

[28] *Abortion Can Be Medically Necessary.* Statement of the American College of Obstetricians and Gynecologists (Sept. 2019), *at* https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary

[29] *Doctor's Organization: Fetal Heartbeat Bills Language Is Misleading*, The Guardian, June 7, 2019, https://www.theguardian.com/world/2019/jun/05/abortion-doctors-fetal-heartbeat-bills-language-misleading

State Restrictions on Reproductive Health Care

ACOG has long opposed unnecessary, unjustified government restrictions on abortion, and works to prevent political interference into medical decision making that is inappropriate, ill-advised, and dangerous.[30] While ACOG recognizes that individuals, including obstetrician-gynecologists, may be personally opposed to abortion, neither politicians nor clinicians should seek to impose their personal beliefs upon patients or allow personal beliefs to compromise patient health, access to and quality of care, or informed consent.[31]

Recent years have seen a dramatic increase in the number and scope of legislative measures restricting abortion. Clinicians across the country are faced with an impossible choice: providing medically appropriate, evidence-based care to a patient—potentially risking civil or criminal penalties, including jail time— or complying with the law and not providing patient care. Examples include:

- **Requirements that clinicians perform specific tests or medical procedures that are not clinically indicated** or generally required for the provision of medically comparable procedures.[32,33]

- **Forcing clinicians to offer or provide patients medically inaccurate information prior to or during abortion services.** Laws that compel physicians to provide or steer patients toward medically inaccurate scripted information are in direct violation of a physician's oath to care. They infringe on patient counseling and manipulate informed consent, an ethical doctrine that is rooted in the concept of self-determination and the fundamental understanding that patients have the right to make their own decisions regarding their own health.[34]

- **Banning abortion at arbitrary gestational ages with no medical justification,** interfering with the ability to provide compassionate and evidence-based care.[35]

- **Banning or restricting abortion based on a person's reason or perceived reason for seeking care,** threatening honest, open conversations between patients and their clinicians.[36]

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[30] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship (reaffirmed August 2021)

[31] *Abortion Policy Statement*, The American College of Obstetricians and Gynecologists, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/abortion-policy (Nov. 2014)

[32] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship (reaffirmed August 2021)

[33] *Legislative interference with the patient-physician relationship.* Weinberger SE, Lawrence HC 3rd, Henley DE, Alden ER, Hoyt DB.. N Engl J Med 2012;367:1557-9.

[34] *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials.* Richardson, C.T., & Nash, E.. Guttmacher Policy Review 2006; 9 (4), 6-11. At https://www.guttmacher.org/sites/default/files/article_files/gpr090406.pdf

[35] *ACOG Statement on Abortion Bans*, The American College of Obstetricians and Gynecologists, https://www.acog.org/news/news-releases/2019/05/acog-statement-on-abortion-bans

[36] *Abortion Can Be Medically Necessary.* Statement of the American College of Obstetricians and Gynecologists (Sept. 2019), *at* https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary

- **Mandating medically specific procedures or diagnostic protocols clinicians must follow.** Decisions about a patient's medical care and management are always best made between the patient and the expert in medical care. Government mandates, such as an ultrasound or pelvic exam before an abortion, force clinicians to practice medicine without regard for clinical best practices.[37]

- **Banning medically indicated procedures, such as dilation and evacuation (D&E)**. The proliferation of bans across the country on the safest and medically preferred abortion procedure in the second trimester tie the hands of physicians. D&E is an evidence-based procedure, and in some cases it is necessary to preserve a patient's health or their future fertility.[38]

- **Holding abortion facilities and clinicians to exhaustive regulatory standards without justification,** including unnecessary structural requirements, and that physicians obtain admitting privileges and transfer agreements at local hospitals. As mentioned previously, ACOG, along with colleague organizations across the women's health and primary care fields, led a rigorous review of the available evidence and guidelines that inform safe delivery of outpatient care. In the published findings, the authors note that in policy and law, regulation of abortion is frequently treated differently from other health services, and false concerns for patient safety are being used as a justification for promoting regulations that specifically target abortion.[39] Targeted facility and staffing requirements make abortion inaccessible for some people and create delays for others, leading to an increase in abortion after the first trimester.[40]

- **Requiring facility inspections and reporting requirements that do not improve safety, jeopardize patient privacy, and intimidate physicians, patients, and clinic staff.**[41]

- **Requiring a patient to make in-person trips prior to an abortion irrespective of any medical justification**. Requiring unnecessary trips (including across state borders) when seeking abortion care imposes prohibitive geographic and financial barriers, and disproportionately negatively impacts people with low incomes, people living in rural areas, and people in states with a paucity of abortion clinics.[42]

- **Bans on telemedicine abortion as an option for patients.** ACOG practice guidelines affirm the safety and effectiveness of telemedicine for medication abortion delivery.[43] Telemedicine is a tool that promises to improve access to many health services in our country, yet states, while innovating telemedicine delivery in many areas of health care, have singled out, rather than

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[37] *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, The American College of Obstetricians and Gynecologists, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship (reaffirmed August 2021)
[38] *Second-trimester abortion*. Practice Bulletin No. 135. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:1394—1406.
[39] *Report from the project on facility guidelines for the safe performance of primary care and gynecology procedures in offices and clinics*. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:255–60.
[40] *Increasing access to abortion.* ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e107–15.
[41] *Id.*
[42] *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from States.* Jerman,J., Frohwirth, L. Kavanaugh, ML. & Blades, N. Perspect Sex Reprod Health. 2017 Jun; 49(2):95-102.
[43] *Medication abortion up to 70 days of gestation*. ACOG Practice Bulletin No. 225. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e31–47.

included, abortion care in these efforts. Peer-reviewed studies have confirmed the safety and effectiveness of medication abortion using telemedicine, including one study that concluded little differentiation in outcomes in a data set of nearly 20,000 patients, and another that evaluated data from across the country and found no difference in safe outcomes by region as well as high rates of patient satisfaction with their experience.[44,45]

- **Restrictions and bans on the use and dispensing of medication abortion**, including mifepristone, one of the safe and effective medications used in a medication abortion regimen.[46]

- **Limiting the pool of appropriately trained and credentialed clinicians from whom patients can access care by banning qualified advanced practice clinicians from providing abortion care and restricting clinical training.** Advanced practice clinicians (APCs) possess the clinical and counseling skills necessary to provide first-trimester abortion safely, and there is no medical rationale or benefit to restricting early abortion care to physicians. A substantial body of evidence demonstrates that APCs can safely and effectively provide early abortion care.[47,48] These studies conclude that complications are rare and no more common for APCs than for physicians.[49] In addition to equivalent efficacy and safety of abortion provision by physicians and APCs, studies also show that patient experience and satisfaction is not statistically different than when the services are provided by physicians.[50]

- **Impeding abortion services even when it is in a clinician's medical judgement that delay would pose a risk to the patient's health.[51]** Pregnancy imposes significant physiological changes on a person's body. These changes can exacerbate underlying or preexisting conditions and can severely compromise health. Physicians should never be put in the position of having to wait for a medical condition to worsen or become life-threatening before being able to provide evidence-based care to their patients, including abortion.

States have imposed a panoply of other barriers to patient care. They include requiring forced waiting periods prior to the provision of abortion care which can, in practice, amount to delays of weeks; insurance coverage bans, both federally and at the state level, that make abortion care cost-prohibitive; and parental involvement requirements that routinely deny minors access to confidential care. None of these restrictions are medically justified. This patchwork of laws substantially limits patient access to care.

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[44] *The TelAbortion project: Delivering the Abortion Pill to your Doorstep by Telemedicine and Mail.* Chong, E., Ryamond, W., Kaneshiro, B., Baldwin, M. Prigue, E., Winikoff, B. Obstetrics & Gynecology: May 2018 - Volume 131 - Issue - p 53S

[45] *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person.* Grossman, D & Gindlay, K. Obstet Gynecol. 2017 Oct;130(4):778-782.

[46] *Improving Access to Mifepristone for Reproductive Health Indications*, The American College of Obstetricians and Gynecologists (June 2018). *At* https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/improving-access-to-mifepristone-for-reproductive-health-indications

[47] *Abortion Training and Education. Committee Opinion No. 612.* American College of Obstetricians and Gynecologists (Reaffirmed 2019). *At* https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Abortion-Training-and-Education

[48] *The Safety and Quality of Abortion Care in the United States.* National Academies of Sciences, Engineering, and Medicine. (March 2018). *At* https://www.nap.edu/read/24950/chapter/1

[49] *Id.*

[50] *Id.*

[51] *Increasing access to abortion.* ACOG Committee Opinion No. 815. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e107–15.

Restrictive legislation also can exacerbate or result in non-legislative obstacles to abortion care. This Committee must consider the threat of stigma, harassment, and fear of violence our members who provide abortion care navigate daily. Since 1993, anti-abortion violence has led to 11 murders and 26 attempted murders. Clinicians who provide abortion care also have been directly targeted with death threats, other threats of harm, and stalking, among other violent acts.[52]

What Abortion Restrictions Mean for People Facing Increased Barriers

Adolescents, people of color, those living in rural areas, those with low incomes, and incarcerated people can face disproportionate effects of restrictions on abortion access.[53] This Committee must consider the already vast access divides that abortion restrictions widen, for example:

- Restrictions and requirements of clinicians who provide abortions, restrictions on the use of telemedicine, and legislatively imposed mandatory delay all have a disproportionate effect on people living in rural areas.

- People living on low incomes most acutely face federal and state restrictions on public and private insurance coverage of abortion, including plans offered through the insurance exchanges established under health care reform.

- As of 2020, parental involvement of some kind in a minor's decision to access abortion is required in 37 states and may contribute to delays accessing care.

- Although people who are incarcerated possess the legal right to abortion, accessibility varies widely.

- Immigrants can face difficulties accessing abortion care, including language and financial barriers, as well as limited knowledge of available services.

- Transgender men and gender-diverse individuals also may face barriers accessing abortion services. [54] Discriminatory policies in the health care system, including abortion restrictions, perpetuate inequities experienced by this population.

What Abortion Restrictions Mean for Physicians and Other Clinicians

Representing more than 62,000 physicians and other providers of women's health care, ACOG takes this opportunity to also highlight for the Committee the lived experiences of our members, and to share what restrictions have meant in real terms for their practices and their patients.

In the face of abortion bans sweeping the country, ACOG has received serious reports of concern from our members impacted by these laws. They have expressed how restrictions and, in some cases, the threat of criminal penalties, impede their ability to provide evidence-based medical care. For example, we heard from one ACOG Fellow in Wisconsin who described how restrictions with limited exceptions and vague legal language created an environment of confusion as to when providing lifesaving care would result in criminal penalties for physicians. Another ACOG Fellow recounted how restrictive policies with limited exceptions force physicians to wait until a patient's health has so deteriorated the they would die without such care. An ACOG Fellow practicing in Pennsylvania noted how the combined restrictions of the Hyde

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[52] *Id.*
[53] *Id.*
[54] *Id.*

Amendment and state insurance prohibitions have limited or delayed access to lifesaving abortion care for their patients. These stories teach us about the real-world impacts of legislative interference in the physician-patient relationship.

Even in states where litigation has halted state restrictions from going into effect, the damage caused can be profound. One ACOG Fellow living in Ohio who is a specialist in high-risk obstetrics recounted that even though some of the most extreme state abortion restrictions are currently blocked by the courts, their mere existence creates confusion for clinicians and patients and undermines patient care, with clinicians never knowing when the legal environment could change and turn them into criminals. In South Carolina, a Fellow relayed how the passage of a six-week ban on abortion, even though it was enjoined, resulted in patient and clinician confusion, cancelled appointments, and disruptions to patient care. The uncertainty and misconceptions caused by proposed state restrictions disproportionately impact people who already are vulnerable to disparities in accessing abortion, including those with low incomes and people of color.[55]

ACOG physicians have also recounted the ways in which their patients accessed abortion care to save their lives and protect their health. Again and again, our physicians' experiences demonstrate that every patient's circumstance is unique, and why one-size-fits-all mandates, combined with medically inaccurate rhetoric and stigma, impose significant harmful barriers to access to care.

Conclusion

ACOG urges Congress to protect patients and their physicians from unwarranted intrusions into the practice of medicine and the patient-physician relationship. We applaud the House of Representatives for taking a critical first step by passing H.R. 3755, the Women's Health Protection Act, to create federal protections against restrictions that have no health benefits and intrude upon the patient-physician relationship. This bill promotes and protects access to abortion services by safeguarding patients and medical professionals from limitations or requirements that single out the provision of abortion services, clinicians who provide and refer for abortion services, and facilities in which abortion services are provided.[56] ACOG urges the Senate to enact this critical legislation. We also encourage passage of H.R. 2234, the Equal Access to Abortion Coverage in Health Insurance (EACH) Act to ensure that everyone, regardless of economic status and geographic location, has access to abortion by repealing the Hyde Amendment.

Thank you for the opportunity to highlight our clinical guidance regarding reproductive health care, the importance of evidence-based research, our members' experiences, and the experiences of the patients for whom they care. ACOG looks forward to continued work with the Committee to protect access to comprehensive reproductive health care.

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[55] *Passage of abortion ban and women's accurate understand of abortion legality.* Gallo MF, Casterline JB, Chakraborty P, et al. Obstetrics & Gynecology: Feb 2021. DOI: https://doi.org/10.1016/j.ajog.2021.02.009
[56] Women's Health Protection Act of 2021, S. 1975, 117th Cong. (2021)