Attachments—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Protecting Women's Access to Reproductive Health Care"
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The Honorable Frank Pallone, Jr. (D-NJ)

1. Ms. Northup – do you agree that the constitutional right to abortion has been severely restricted as a result of action in the states? Can you give us some examples of how abortion is limited even while Roe stands?

    Yes. Although *Roe v. Wade* was decided almost fifty years ago[1] and the right to abortion access has been repeatedly upheld by the Supreme Court, anti-abortion politicians have nonetheless engaged in a coordinated assault on abortion access to ensure that patients face insurmountable barriers to care and that clinics are forced to close—effectively banning abortion without ever having to touch *Roe v. Wade*.

    Since 2011, state legislatures have enacted nearly 450 state laws restricting and banning abortion care.[2] These restrictions include six-week bans, ambulatory surgical center requirements, mandatory ultrasound requirements, biased counseling requirements, and requirements that providers obtain admitting privileges at local hospitals.[3] These restrictions provide no medical benefit. Instead, they are designed to obstruct and delay abortion access, and prevent people from making personal decisions about their health, their lives, and their futures.[4] Most recently, we've seen officials in multiple states exploiting the current COVID-19 pandemic public health emergency to attempt to ban abortion, forcing patients to travel hundreds of miles and cross state lines—putting themselves and their families at risk—in order to access care.

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[1] *Roe v. Wade*, 410 U.S. 113 (1973).
[2] CTR. FOR REPROD. RTS., *What if Roe Fell* (2019), https://reproductiverights.org/what-if-roe-fell (last visited Apr. 20, 2020).
[3] *Id.*
[4] GUTTMACHER INST., *Targeted Regulation of Abortion Providers (TRAP) Laws* (Jan 2020), https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws#trap.

2. Has this resulted in unequal access to abortion depending on where someone lives?

Yes. As anti-abortion state legislatures have continued to pass restrictions intent on closing clinics, abortion care has become increasingly difficult or even impossible to access in broad swaths of the country. In 1992, the year that *Planned Parenthood v. Casey*[5] was decided, there were 2,380 clinics in the United States. In 2017, there were 1,587—a decrease of one third.[6] And laws that lead to clinic closures have a lasting effect, even after they have been struck down. For example, nearly half of Texas' abortion clinics were forced to close after the enactment of the state's admitting privileges law, almost none of which were able to reopen years after the Supreme Court held that the law was unconstitutional.[7]

Six states are now down to one abortion clinic[8] and nearly 90 percent of American counties are without a single abortion provider.[9] The harms caused by the decimation of abortion access are deeply unequal, falling most heavily on marginalized and underserved people and communities who already experience significant structural and systemic barriers to accessing quality health care, including abortion.

These barriers to access have become even more pronounced during the COVID-19 crisis as some states long-hostile to abortion access have exploited this serious health emergency to close abortion clinics without medical justification. The COVID-19 clinic closures are clearly a pretextual attempt to circumvent the guarantees of *Roe v. Wade*, made evident by the fact that such closures directly contravene the guidance of leading health and medical authorities. The American Medical Association ("AMA") cautioned that such attempts by state officials are "exploiting this moment" and warned that "physicians—not politicians—should be the ones deciding which procedures are urgent-emergent and need to be

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[5] *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

[6] Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services In The United States, 1991 and 1992*, 26(3) FAM. PLANNING PERSP. 100-106 (1994), https://www.ncbi.nlm.nih.gov/pubmed/8070545 (finding that in 1992, there were 2,380 facilities providing abortion); Rachel K. Jones, Elizabeth Witwer & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2017*, GUTTMACHER INST. (Sept. 2019), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017 (finding that in 2017, 1,587 health care facilities were known to provide abortions).

[7] Carrie Feibel, *Half of Texas Abortion Clinics Close After Restrictions Enacted*, NPR (July 18, 2014), https://www.npr.org/sections/health-shots/2014/07/18/332547328/half-of-texas-abortion-clinics-close-after-restrictions-enacted; Ashley Lopez, *For Supporters of Abortion Access, Troubling Trends in Texas*, NPR (Nov. 18, 2019), https://www.npr.org/sections/health-shots/2019/11/18/741117422/for-supporters-of-abortion-access-troubling-trends-in-texas.

[8] Holly Yan, *These 6 States Have Only 1 Abortion Clinic Left*, CNN (May 29, 2019), https://www.cnn.com/2019/05/29/health/six-states-with-1-abortion-clinic-map-trnd/index.html.

[9] Jones, *supra* note 6.

performed."[10] The American College of Obstetricians and Gynecologists ("ACOG") and seven other leading medical and health organizations also made clear that, during the COVID-19 pandemic, abortion care is essential because it cannot be delayed without risking the health and safety of the patient.[11] ACOG and the AMA have weighed in to say state actions banning abortion care are "likely to increase, rather than decrease, burdens on hospitals and use of PPE. At the same time, [they] will severely impair essential health care for women and place doctors, nurses, and other medical professionals in an untenable position by criminalizing necessary medical care."[12]

3. Does this mean that despite having a constitutional right to abortion, in reality, accessing that right is often dependent on a person's location, their financial situation, and other factors that may make obtaining an abortion more difficult?

Absolutely. The harms created by these medically unnecessary restrictions are deeply unequal, falling most heavily on underserved people and communities,[13] including people of color,[14] young people, people with low incomes,[15] LGBTQ people,[16] people with disabilities, immigrants[17] and people living in rural or medically underserved areas.[18] People seeking care in locations with limited access need to take extra time away from work and pay for additional childcare, transportation, and lodging in order to travel to clinics outside of their

[10] Patrice A. Harris, President, Am. Med. Ass'n, *AMA Statement on Government Interference in Reproductive Health Care* (Mar. 30, 2020), https://www.ama-assn.org/press-center/ama-statements/ama-statement-government-interference-reproductive-health-care.

[11] Am. Coll. of Obstetricians & Gynecologists et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

[12] Br. of Am. Coll. of Obstetricians & Gynecologists, Am. Med. Ass'n, & Other Nationwide Orgs. of Med. Profs. as Amici Curiae in Opp'n to the Pet. for a Writ of Mandamus at 5, *In re: Abbott*, No. 20-50264 (5th Cir. Apr. 2, 2020).

[13] Am. Coll. of Obstetricians & Gynecologists, *Increasing Access to Abortion. Committee Opinion No. 613,* 124 OBSTETRICS & GYNECOLOGY 1060 (2014), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/increasing-access-to-abortion (discussing the impact of abortion restrictions on rural and otherwise medically underserved people).

[14] Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22(2) J HEALTH CARE POOR UNDERSERVED 415 (2011), available at https://www.ncbi.nlm.nih.gov/pubmed/21551921 (discussing impeded abortion access for women of color and low-income women).

[15] *Id*.

[16] Jen Kates, Usha Ranji, Adara Beamesderfer, Alina Salganicoff & Lindsey Dawson, *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, KAISER FAM. FOUND. (May 2018), https://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/.

[17] Usha Ranji, Michelle Long & Alina Salganicoff, *Beyond the Numbers: Access to Reproductive Health Care for Low-Income Women in Five Communities*, KAISER FAM. FOUND. (Nov. 19, 2019), https://www.kff.org/report-section/beyond-the-numbers-access-to-reproductive-health-care-for-low-income-women-in-five-communities-executive-summary/.

[18] Am. Coll. of Obstetricians & Gynecologists, *supra* note 13.

communities and comply with state laws that exist solely to make abortion care difficult to obtain.[19]

If state attacks on abortion access go unabated, this constitutionally protected and necessary health care will be pushed even further out of reach and in many cases become completely inaccessible.

In fact, for the first time in decades, anti-abortion extremists attempting to use the COVID-19 crisis as a pretext to ban abortion temporarily left women in multiple states without access to essential care. Access to abortion care in Texas[20] and Oklahoma[21] has been intermittently available, and other states have attempted to force clinics to close by using the pandemic as pretense to attack abortion care.[22]

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[19] Liza Fuentes & Jenna Jerman, *Distance Traveled to Obtain Clinical Abortion Care in the United States and Reasons for Clinic Choice*, 28(12) J OF WOMEN'S HEALTH 1623 (Dec. 10, 2019), available at https://www.liebertpub.com/doi/10.1089/jwh.2018.7496; Rebecca S. Rouland, Gretchen E. Ely & Amelia Caron, *Abortion Patient Experiences of the Forty-Eight-Hour Waiting Period Policy in Tennessee*, 25(1) J OF APPALACHIAN STUDIES 87 (2019), available at https://www.jstor.org/stable/10.5406/jappastud.25.1.0087.

[20] Press Release, Ctr. for Reprod. Rights, 5th Circuit Court of Appeals Backs Down, Restores Medication Abortion in Texas For Now (Apr. 14, 2020), https://reproductiverights.org/press-room/5th-circuit-court-appeals-backs-down-restores-medication-abortion-texas-now; Caroline Kitchener, *One day abortion is legal, the next day it's not: Coronavirus sparks a ping-pong fight in Texas,* THE LILY (Apr. 22, 2020), https://www.thelily.com/one-day-abortion-is-legal-the-next-day-its-not-coronavirus-sparks-a-ping-pong-fight-in-texas/; Editorial Board, *Texas politicians are cruelly exploiting the coronavirus crisis to limit access to abortions,* WASHINGTON POST (Apr. 15, 2020), https://www.washingtonpost.com/opinions/texas-politicians-are-cruelly-exploiting-the-coronavirus-crisis-to-limit-access-to-abortions/2020/04/14/0c4ed848-7e8d-11ea-8013-1b6da0e4a2b7_story.html; Jen Rice, *With Temporary Pandemic Restrictions Lifted, Houston Abortion Providers Prepare For a Surge,* HOUSTON PUBLIC MEDIA (Apr. 23, 2020), https://www.houstonpublicmedia.org/articles/news/health-science/2020/04/23/367866/with-temporary-pandemic-restrictions-lifted-houston-abortion-providers-prepare-for-a-surge/

[21] Press Release, Ctr. for Reprod. Rights, Court Says Oklahoma Abortion Providers Can Stay Open as COVID-19 Lawsuit Continues (Apr. 21, 2020), https://reproductiverights.org/press-room/court-says-oklahoma-abortion-providers-can-stay-open-covid-19-lawsuit-continues; Carmen Forman, *Coronavirus in Oklahoma: All Oklahoma abortions can resume Friday, judge orders,* THE OKLAHOMAN (Apr. 22, 2020), https://oklahoman.com/article/5660593/all-oklahoma-abortions-can-resume-friday-judge-orders

[22] Valerie Kipnis, *Coronavirus Has Created Abortion Deserts Across the U.S.,* VICE (Apr. 23, 2020), https://www.vice.com/en_us/article/epgy5w/coronavirus-has-created-abortion-deserts-across-the-us (noting that Texas, Arkansas, Alaska, Mississippi, Tennessee, Utah, Oklahoma, Ohio, Indiana, Kentucky, Alabama, Louisiana, & West Virginia have tried to curtain abortion access in some way under COVID-19-related bans); Hailey Konnath, Katie Pohlman, Danielle Nichole Smith & Jeff Overley, *5 New COVID-19 Abortion Developments You Should Know,* LAW360 (APR. 14, 2020), https://www.law360.com/articles/1263360/5-new-covid-19-abortion-developments-you-should-know (detailing court developments related to attacks on abortion care during the COVID-19 crisis in Texas, Oklahoma, Louisiana, Arkansas, & Alabama); Press Release, Ctr for Reproductive Rights, Louisiana's COVID-19 Ban on Abortion Challenged in Court (Apr. 14, 2020), https://reproductiverights.org/press-room/louisianas-covid-19-ban-abortion-challenged-court; Mary Ann Pazanowski, *Louisiana Covid-19 Order Challenged by Abortion Providers,* BLOOMBERG LAW (Apr. 14, 2020), https://news.bloomberglaw.com/health-law-and-business/louisiana-covid-19-order-challenged-by-abortion-providers (detailing challenge to a Louisiana COVID-19-related order indefinitely banning abortion services); Jonathan Mattise & Kimberlee Kruesi, *Lawmakers pushed Tennessee gov to toughen virus abortion ban*, THE ASSOCIATED PRESS (Apr. 21, 2020), "https://apnews.com/2c5fb70c9f6946f64b7b68ed020460a8 (detailing push to ban abortions in Tennessee); Linda

4. Do we need additional protections to ensure that the constitutional right to abortion can be equally accessible to all who need it?

Yes. The Women's Health Protection Act[23] would ensure that the right to abortion first recognized nearly fifty years ago in *Roe v. Wade* can be realized by people across the United States, no matter what state they happen to live in. This bill would create a federal statutory right for providers to provide abortion services, and a corresponding right for their patients to receive abortion services, free from bans and medically unnecessary restrictions that single out abortion and impede access to care.[24]

Even with Roe v. Wade as the law of the land, anti-abortion rights lawmakers are legislating abortion out of existence by attacking access, fueling a relentless cycle of harmful state laws and the prolonged court fights that follow. The right to access abortion care generally continues to be upheld by Federal and state courts, but anti-abortion rights politicians are not deterred, passing increasingly extreme laws intended to impede access. The Women's Health Protection Act would provide clear, upfront guidance to states and courts regarding the rights of providers and patients, allowing the provision of abortion care free from medically unnecessary restrictions.

In addition to passing the Women's Health Protection Act, Congress must pass H.R.1692: The EACH Woman Act. The EACH Woman Act would eliminate bans on insurance coverage of abortion, ensuring that abortion is truly accessible regardless of income.[25]

Satter, *Judge lets abortions in state go on for now,* ARKANSAS DEMOCRAT GAZETTE (Apr. 15, 2020), https://www.arkansasonline.com/news/2020/apr/15/judge-lets-abortions-in-state-go-on-for/?news-politics (detailing temporary order prohibiting Arkansas from banning abortion during the COVID-19 crisis)ARKANSAS DEMOCRAT GAZETTE (Apr. 15, 2020), https://www.arkansasonline.com/news/2020/apr/15/judge-lets-abortions-in-state-go-on-for/?news-politics (detailing temporary order prohibiting Arkansas from banning abortion during the COVID-19 crisis).

[23] Women's Health Protection Act of 2019, H.R. 2975, 116th Cong. (2019).

[24] H.R. 2975 Sec. 4 (2019).

[25] Equal Access to Abortion Coverage in Health Insurance (EACH Woman) Act of 2019, H.R. 1692, 116th Cong. (2019).

The Honorable Anna G. Eshoo (D-CA)

1. How would the Women's Health Protection Act (WHPA) impact the practice of providers who do not want to provide abortion care?

   The Women's Health Protection Act does not compel health care providers to provide abortion care, and thus, a health care provider who does not wish to provide abortion care will not be impacted.[26]

   Moreover, WHPA does not contravene existing federal statutes that allow healthcare providers to decline to provide abortion services based on their personal religious beliefs.[27]

2. Is there any state in the US where someone who is not a licensed medical professional can practice medicine under state law?

   No. It is illegal across the country for someone without a medical license to practice medicine.[28]

   During the hearing, a witness for the minority testified that "There are some states in this country where you don't even have to be a licensed medical professional to perform an abortion... Vermont is an example, I believe." This is not accurate. In Vermont, as across the United States, all medical providers must be licensed.[29]

3. How does WHPA improve laws around informed consent?

   The concept of informed consent is predicated on the conveyance of accurate, timely medical information between trusted providers and their patients. WHPA protects informed consent from harmful state restrictions that violate this important principle. Specifically, in an attempt to shame and stigmatize women who seek abortion, some states have forced providers to give patients medically inaccurate information about abortion, including that abortion increases the risk of depression and breast cancer and that medication abortion can be reversed.[30] These requirements undermine the patient-provider relationship and hinder a patient's ability to accurately weigh risks and benefits and make a well-informed decision. WHPA protects the informed consent process by creating a federal

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[26] Note that in the operative language under Permitted Services in both Sections 4(a) and 4(b), the bill clearly states that a health care provider "may" provide services, not that a health care provider "must" provide services.

[27] See "Church Amendments," 42 U.S.C.A. §300a-7 et seq.; Public Health Service Act, 42 U.S.C.A. § 238n; Weldon Amendment, Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 507(d), 133 Stat. 2534, 74 (2019).

[28] E.g., Texas: 3 Tex. Occupations Code § 165.159 (1999); California: Cal. Bus. & Prof. Code § 2052 (2011); Maine: 32 Me. Rev. Stat. § 3266, 3269, 3271, 3276-3278, 3280-A, 3300-D (2017); 10 Me. Rev. Stat. § 8003(5)(C), 8003-E, 8011(4) (2017); Wisconsin: Wis. Stat. § 448.03 (2012).

[29] 26 Vt. Stat. § 1314 (2011).

[30] CTR. FOR REPROD. RTS., *supra* note 2.

safeguard against any such requirements that providers give medically inaccurate information to their patients.[31]

The Honorable Ann Kuster (D-NH)

1. Ms. Northup, can you describe some of the state restrictions and bans that specifically harm women living in rural areas in particular?

Most, if not all, of the state-level restrictions and bans have an outsize impact on people living in rural areas, which are often medically underserved. Restrictions such as admitting privileges requirements that close clinics and increase the distance that someone will have to travel for abortion care disproportionately impact individuals in rural areas. Long travel distances to access abortion care are exacerbated by mandatory waiting periods and requirements that patients make multiple, medically unnecessary visits to a clinic in order to access care. For many pregnant people living in rural areas, the cost and time required to travel such distances and stay overnight are prohibitive.

Because of the outsize effect of clinic closures and restrictions like waiting periods for people living in rural areas, the ability to access abortion care through telemedicine is paramount. Medication abortion can be safely and effectively administered through telehealth consultations, but some states have restricted providers' ability to provide abortion care remotely in order to eliminate this option.[32]

States like Iowa have developed innovative service models to incorporate rural health care providers into the provision of abortion care, allowing patients to video conference with providers to determine their eligibility for medication abortion and then retrieve the medications from clinics close to their homes. Abortion care delivered through models has proven just as safe as in-person provision of medication abortion, with high levels of patient satisfaction.[33] Despite the safety and efficiency of these models, anti-abortion lawmakers have continued to pass restrictions, including those banning telemedicine for

[31] H.R. 2975 Sec. 4(a)(3) (2019).
[32] GUTTMACHER INST., *Medication Abortion* (Apr. 1, 2020), https://www.guttmacher.org/state-policy/explore/medication-abortion.
[33] Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person,* 103(4) OBSTETRICS & GYNECOLOGY 778 (Oct. 2017), available at https://www.ncbi.nlm.nih.gov/pubmed/28885427; Margit Endler et al., *Telemedicine for medical abortion: a systematic review*, 126(9) BRIT. J. OF OBSTETRICS AND GYNAECOLOGY 1094 (Mar. 14, 2019), available at https://doi.org/10.1111/1471-0528.15684.

medication abortion, that they know will make abortion difficult to access in rural areas.

2. How many states have acted to limit telemedicine for abortion care and what steps have they taken?

Eighteen states prohibit the use of telemedicine for medication abortion care, by requiring a prescribing provider to be physically present in the same room as their patient when providing abortion-inducing pills.[34] Other states, such as Arkansas, have gone a step even further, exempting the provision of abortion from the practice of telemedicine.[35]

These restrictions require patients to make medically unnecessary in-person trips to a clinic, despite the overwhelming clinical evidence that the safety and effectiveness of medication abortion remains the same whether it is provided via telemedicine or through in-person provision, as shown by a seven-year cohort study with tens of thousands of patients,[36] systematic reviews[37], and an evaluation of a telemedicine abortion service across five states.[38] An independent analysis conducted by the National Academies of Science, Engineering and Medicine has similarly concluded that, "there is no evidence that the dispensing or taking of mifepristone tablets requires the physical presence of a clinician."[39]

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[34] GUTTMACHER INST., *supra* note 32 (citing laws in Alabama, Arizona, Arkansas, Indiana, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia, and Wisconsin; in addition to Iowa, where the law is permanently enjoined by court order and not in effect.)
[35] Ark. Code Ann. § 17-80-407(2).
[36] Grossman, *supra* note 33.
[37] Endler, *supra* note 33.
[38] Elizabeth Raymond et al., *TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States,* 100(3) CONTRACEPTION 173 (Sep. 2019), available at https://doi.org/10.1016/j.contraception.2019.05.013.
[39] NAT'L ACADS. OF SCIENCES, ENGINEERING, AND MEDICINE, *The Quality of Abortion Care Depends on Where a Woman Lives, Says One of Most Comprehensive Reviews of Research on Safety and Quality of Abortion Care in the U.S.* (March 16, 2018), https://www.nationalacademies.org/news/2018/03/the-quality-of-abortion-care-depends-on-where-a-woman-lives-says-one-of-most-comprehensive-reviews-of-research-on-safety-and-quality-of-abortion-care-in-the-us.

3. What steps can Congress take to improve access to care for women in rural areas specifically?

Congress should pass the Women's Health Protection Act[40] to improve abortion access for people across the country, including those in rural areas.

The bill creates a statutory right for abortion providers to provide abortion care free from medically unnecessary restrictions, such as multiple mandatory trips to a clinic, as well as a corresponding right for their patients to receive that care. Many of these restrictions disproportionately impact people living in rural communities by increasing the distance that patients must travel to receive care, increasing the costs associated with that care, and, for many, pushing abortion completely out of reach.[41]

The Women's Health Protection Act addresses this disparity by expressly identifying a specific set of restrictions that constitute a violation of these statutory rights, including, for example, bans on telemedicine for the provision of abortion care. The Act further lays out a set of criteria that courts must consider in determining whether a restriction violates the statutory right to abortion, including whether the restriction treats abortion differently than medically comparable procedures or services and impedes access to care.

By safeguarding abortion access from such discriminatory restrictions, and by blocking barriers that increase travel time and exacerbate associated burdens such as finding childcare, taking time off work, and arranging for transit, the Women's Health Protection Act would broadly improve access to care for people in rural areas.

4. Would the Women's Health Protection Act improve access to care for women in rural areas?

Yes. The Women's Health Protection Act would eliminate a number of the barriers to care currently affecting women in rural areas. By creating a statutory right for abortion providers to provide care free from medically unnecessary restrictions, and a corresponding right for their patients to receive that care, the Women's Health Protection Act would put an end to the restrictions and bans that put abortion care out of reach for people in rural areas. These restrictions include mandatory waiting periods, requirements for multiple trips,[42] bans on the

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[40] H.R. 2975 Sec. 4(a) (2019).
[41] AM. CIV. LIBERTIES UNION, *Government-Mandated Delays Before Abortion* (2020), https://www.aclu.org/other/government-mandated-delays-abortion.
[42] H.R. 2975 Sec. 4(a)(7) (2019).

provision of abortion care through telemedicine,[43] and admitting privileges laws that serve only to shut down clinics.[44]

[43] H.R. 2975 Sec. 4(a)(5) (2019).
[44] H.R. 2975 Sec. 4(a)(6) (2019).