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

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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.