Good morning, Chairman Bizzarro and Chairwoman Muth, and the House Democratic Policy Committee. My name is Marian Jarlenski, and I am an Associate Professor of Health Policy and Management and Associate Director of the Center for Innovative Research on Gender Health Equity at the University of Pittsburgh School of Public Health. I appreciate the opportunity to contribute to this hearing by providing information about public health research related to abortion care.

Why do people seek abortions?

Reasons for seeking abortion are multi-faceted and reflect personal experiences, socio-economic factors, and medical circumstances. The majority of people seeking an abortion identify a financial inability to parent a child as a reason they sought care.[1,2] Many people also describe the need to care for the children they already have, or a desire to have children at a different time in their lives, as a reason for seeking an abortion. Approximately 10% of people seek abortion because of medical risks in pregnancy. Finally, people seek abortion for pregnancies due to sexual assault or coercion. A small proportion of abortion patients disclose seeking care because of rape[1], although 1 in 5 women report needing the abortion because of an unsupportive or abusive relationship with a male partner.[2]

What are the health effects of access to desired, legal abortion care?

A 2018 report by the National Academy of Medicine found "the clinical evidence clearly shows that legal abortions in the United States…are safe and effective. Serious complications are rare."[3] The report also concluded that having an abortion does *not* increase the future risk of infertility, preterm birth, hypertensive disorders, or breast cancer.[3] The most robust public health evidence on health effects comes from the Turnaway Study,[a] which included 1,000 women seeking abortion care near the gestational age limits for the procedure, and followed them for up to 5 years to track their health.[4] Because the fact of

[a] An annotated bibliography of peer-reviewed publications from the Turnaway Study is available at: https://www.ansirh.org/sites/default/files/2022-07/turnawaystudyannotatedbibliography063022.pdf

whether women received the abortion was essentially random, data from this study shed light on the causal effects of receiving or being denied a wanted abortion. Results from the Turnaway study suggest that being denied a wanted abortion has negative health consequences in the short-term, including serious pregnancy complications and poor mental health. However, longer-term trajectories of health between people who did and did not obtain an abortion were often similar.

For those who seek abortion care related to pregnancy complications, denial of care could lead to increased risk for life-threatening conditions and death. One study estimated that pre-*Dobbs* state abortion restrictions were associated between a 2% and 12% increase in maternal mortality.[5] A recent Texas study of 28 patients with high-risk pregnancy complications found more than half experienced severe maternal morbidity when forced to wait for their conditions to deteriorate in order to be eligible for a medically necessary abortion.[6] While new evidence is emerging, research is not yet available to fully understand the impact of state abortion bans on care for high-risk pregnancy complications and subsequent health.

What is the impact of health insurance coverage for abortion care?

The median out-of-pocket cost for obtaining a first-trimester abortion, not including travel, is close to $600, well beyond the means of many families.[7] Despite that, health insurance coverage for abortion care varies widely according to state policies.[b] The single-largest source of health insurance for people of reproductive age in the United States is Medicaid. Because Congress has barred federal funding for abortion,[c] Medicaid programs may use state-only funds to cover medically necessary abortion care, but most don't. Research suggests that state Medicaid coverage of medically necessary abortion care reduces the risk of severe maternal morbidity[8] as well as reducing the risk of infant death due to congenital

[b] This was the case even before states began banning abortion care in the wake of the Texas SB8 law and the *Dobbs* decision.

[c] The Hyde Amendment is a rider attached to all annual federal appropriations laws stating that federal funds cannot be used to pay for abortion care or health insurance which pays for abortion care except in cases of life endangerment of the pregnant person, or in cases of rape or incest. The rider is named for its sponsor, Henry J. Hyde, who served as a member of Congress for some 30 years.

anomalies.[9] In private health insurance plans, the availability of coverage for abortion care is similarly dependent on state policies. More research will be needed to understand how insurance coverage of abortion care or coverage of travel for such care affects health outcomes.

In conclusion, the weight of the public health evidence suggests that legal abortion care is safe and that arbitrary restrictions on access to needed abortion care are likely to have adverse consequences for the public's health. For these reasons, more than 75 different medical societies joined the American College of Obstetricians and Gynecologists to state that "Abortion care is safe and essential reproductive healthcare."[10]

REFERENCES

1. Finer LB, Frohwirth LF, Dauphinee LA, Singh S, Moore AM. Reasons U.S. women have abortions: quantitative and qualitative perspectives. *Perspect Sex Reprod Health*. Sep 2005;37(3):110-8. doi:10.1363/psrh.37.110.05
2. Biggs MA, Gould H, Foster DG. Understanding why women seek abortions in the US. *BMC Womens Health*. Jul 5 2013;13:29. doi:10.1186/1472-6874-13-29
3. National Academies of Sciences Engineering and Medicine. *The safety and quality of abortion care in the United States*. 2018. https://www.nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states
4. Foster DG. *The turnaway study : ten years, a thousand women, and the consequences of having--or being denied--an abortion*. Scribner; 2020:pages cm.
5. Vilda D, Wallace ME, Daniel C, Evans MG, Stoecker C, Theall KP. State Abortion Policies and Maternal Death in the United States, 20152018. *Am J Public Health*. Sep 2021;111(9):1696-1704. doi:10.2105/AJPH.2021.306396
6. Nambiar A, Patel S, Santiago-Munoz P, Spong CY, Nelson DB. Maternal morbidity and fetal outcomes among pregnant women at 22 weeks' gestation or less with complications in 2 Texas hospitals after legislation on abortion. *Am J Obstet Gynecol*. Jul 5 2022;doi:10.1016/j.ajog.2022.06.060
7. Upadhyay UD, Ahlbach C, Kaller S, Cook C, Munoz I. Trends In Self-Pay Charges And Insurance Acceptance For Abortion In The United States, 2017-20. *Health Aff (Millwood)*. Apr 2022;41(4):507-515. doi:10.1377/hlthaff.2021.01528
8. Jarlenski M, Hutcheon JA, Bodnar LM, Simhan HN. State Medicaid Coverage of Medically Necessary Abortions and Severe Maternal Morbidity and Maternal Mortality. *Obstet Gynecol*. May 2017;129(5):786-794. doi:10.1097/AOG.0000000000001982
9. Hutcheon JA, Bodnar LM, Simhan HN. Medicaid pregnancy termination funding and racial disparities in congenital anomaly-related infant deaths. *Obstet Gynecol*. Jan 2015;125(1):163-169. doi:10.1097/AOG.0000000000000583
10. More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference. 2022. https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizations-release-joint-statement-in-opposition-to-legislative-interference