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 the state of public health research related to 3 topics: reasons why people seek abortion care; the health effects of receiving or not receiving desired abortion care; and the landscape of health insurance coverage for abortion care.

Why do people seek abortions?

Several large surveys have asked people their reasons for seeking an abortion.[a] Research shows that reasons for seeking abortion are multi-faceted and reflect personal experiences, socio-economic factors, and medical circumstances. The most frequently cited reason for seeking an abortion relates to economic concerns. Between 40% to 75% of persons seeking abortion, depending on the survey, identified the financial inability to parent a child as the reason they sought abortion care.[1,2] Relatedly, many people also describe the need to care for the children they already have as a reason for seeking an abortion. Another common reason for seeking an abortion is timing of the pregnancy – in other words, people are concerned that they are too old or too young to parent a child, or wanted to be pregnant at a different time in their lives. A third reason is health concerns. Approximately 10% of people seek abortion because of maternal and/or fetal medical risks in pregnancy. Finally, people seek abortion for pregnancies related to sexual assault or gender-based violence. One national study showed only 1% of abortion patients explicitly

[a] Statistics in this paragraph draw on results of two large surveys. The Guttmacher Abortion Patient Survey includes a national sample of approximately 1,200 patients who receive abortion care at clinics around the United States. The Turnaway Study is a longitudinal cohort study that included nearly 1,000 women seeking abortion care in mid-pregnancy, approximately half of whom received abortion care.

identified seeking care because of rape.[1] However, in a different study,[b] 1 in 5 women seeking abortion reported needing the abortion because of an unsupportive or abusive relationship with a male partner.[2]

Socioeconomic status and abortion

The United States has historically offered less public financial support to families with young children relative to comparable nations, resulting in a child poverty rate that has hovered close to 20%, in contrast to rates of less than 10% in many high-resource nations.[3] Moreover, because unwanted pregnancy disproportionately occurs among those who are economically disadvantaged in the United States, 49% of all abortions occur among people whose household income is <100% of the federal poverty threshold.[4] The United States implemented a federal advance child tax credit, which increased progressively among lower-income households, in effect from July to December 2021. Economists have estimated that this tax credit reduced the number of U.S. children living in poverty by 40%.[5] Pennsylvania recently adopted a new state child tax credit program that is modeled on the federal program, set to take effect in 2023. Currently, there is no available research that addresses the question of whether these recent efforts to financially support parents reduced the likelihood of seeking abortion for financial reasons.[c]

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

A 2018 report by the National Academy of Medicine states "the clinical evidence clearly shows that legal abortions in the United States…are safe and effective. Serious complications are rare."[6] Epidemiological

[b] See Table 2. Within the Partner-Related Reasons, 9% of respondents said they lacked a good or stable relationship, 8% said their partner was not supportive, and 3% said their partner was abusive.

[c] For a discussion of the 1990s welfare reform and abortion rates, see Chapter 5 in *Welfare, The Family, And Reproductive Behavior: Research Perspectives*. Moffitt RA, editor. Washington (DC): National Academies Press (US); 1998.

research estimates that pregnancy and childbirth carries 14 times the risk of death, compared to a legal abortion.[7,8]

The National Academy of Medicine report also concluded that having an abortion does *not* increase the risk of future infertility, preterm birth, hypertensive disorders, or breast cancer.[6] The most robust public health evidence on longer-term health effects comes from the Turnaway Study,[d] which recruited 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 outcomes.[9] Because the fact of whether women received the abortion was essentially random, the data from this study allow us to draw inference on the causal effects of receiving or being denied a wanted abortion.

In the Turnaway Study, 6.3% of those who were denied a desired abortion experienced a life-threatening pregnancy complication.[10] After 5 years of follow-up, women who were denied a wanted abortion had a greater odds of reporting fair to poor health status (as opposed to good or excellent), relative to those who received a wanted abortion.[11] However, there was no difference between groups on other long-term measures of physical health, such as chronic pain, obesity, and diabetes.[11] Findings also indicate having a desired abortion does not have an impact on long-term mental health outcomes. After 5 years of follow-up women who receive a wanted abortion and those denied a wanted abortion had similar trajectories of suicidal ideation (which was rare),[12] post-traumatic stress syndrome,[13] and depression and anxiety.[14] However, most women who were denied a wanted abortion reported being unable to pay for basic needs for their children.[15]

In summary, for people seeking abortion care, there is no robust evidence that access to abortion care is harmful. In contrast, the available evidence suggests that being denied a wanted abortion has negative

[d] 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

health consequences in the short-term, but longer-term trajectories of health between people who did and did not obtain an abortion are often similar. Despite the strengths of the Turnaway Study analytic design, more research and different approaches are needed to continue to investigate the effects of denials of abortion care in the new era of state abortion bans.

High-risk pregnancy complications and access to abortion care

There are a wide range of pre-existing and pregnancy-specific conditions that could significantly increase the risk of morbidity or mortality during pregnancy. The burden of chronic conditions in pregnancy has been increasing in the United States in recent decades,[16] and this trend is believed to be a major factor in the increasing rates of severe maternal morbidity and mortality. The rate of maternal mortality in the United States far exceeds that of comparable nations,[17] and Black people have approximately 3-fold higher rate of pregnancy-related mortality compared to white people. The most recent data demonstrate an alarming widening of this racial inequity from 2018-2020,[18] with a Black mortality rate of 55.3 per 100,000 in 2020 compared to a white mortality rate of 19.1 per 100,000. Rates of severe maternal morbidity (SMM), which encompasses life-threatening conditions during pregnancy and postpartum, have increased by nearly 200% in the past 20 years,[19-22] and significant racial inequities exist in SMM as well.[23-25] If people are unable to access abortion care in cases of high-risk pregnancy complications, it could lead to further increases in severe maternal morbidity and death. One study estimated that pre-*Dobbs* state abortion restrictions were associated between a 2% and 12% increase in maternal mortality.[26] New evidence is now emerging about the impact of state abortion bans on pregnancy outcomes. One recent Texas study of 28 patients with high-risk pregnancy complications showed that 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.[27] In contrast, prior to the Texas abortion ban, a third of such patients experienced severe maternal morbidity.[27] Research evidence is not yet available to fully understand the impact of state abortion bans on care for high-risk pregnancy complications and subsequent outcomes.

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

Health insurance coverage for abortion care varies widely according to state policies.[e] The single-largest source of health insurance for people of reproductive age in the United States is Medicaid. Because federal appropriations laws have barred any federal funding for abortion care each year since 1976,[f] Medicaid programs may use state-only funds to cover medically necessary abortion care. As of 2021, 16 state Medicaid programs opted to do so.[28] Research suggests that state Medicaid coverage of medically necessary abortion care reduces the risk of severe maternal morbidity[29] as well as reducing the risk of infant death due to congenital anomalies.[30] In the landscape of private health insurance plans, the availability of coverage for abortion care is similarly dependent on state policies. Private health insurance plans offered through the state Health Insurance Marketplaces are prohibited from covering abortion care using federal funds;[g] although a handful of states offer such coverage in their Marketplace plans using separate funds. Likewise, 7 states currently require insurance coverage of abortion care in private policies written in the state, while 11 states prohibit health insurance of abortion care in private insurance policies and 22 states prohibit public employee health insurance plans from covering abortion care.[31, h] There is scant evidence available on the effects of private insurance mandates on access to abortion and health outcomes. Nevertheless, a recent study finds the median out-of-pocket costs for obtaining a first-trimester abortion, not including travel costs, was close to $600.[32] More research is needed to understand how

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

[f] 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.

[g] Prior to the Affordable Care Act, most individual health insurance plans would cover abortion but not cover maternity care, due to the high risks of medical costs associated with pregnancy and childbirth. The ACA mandated health insurance plans to cover maternity care but banned coverage of abortion care with federal funds.

[h] According to the Guttmacher Institute analysis, Pennsylvania prohibits insurance coverage of abortion care in Medicaid, Health Insurance Marketplace, and state employee plans except in cases of life endangerment, rape, or incest.

employer-sponsored insurance coverage, and other private insurance coverage of abortion care and related travel for care, affects health outcomes.

Insurance coverage, access to contraception, and abortion

Unfettered access to the full range of contraceptive methods, including the choice to use or not use contraception, is a core component of high-quality healthcare. Access to contraception has been associated with reductions in unwanted pregnancies, abortion, and pregnancy-related morbidity and mortality.[33] Furthermore, policies to increase access to contraception are cost-saving for healthcare systems.[34-36] The Affordable Care Act (ACA) mandated coverage of the full range of contraception methods and has improved access to affordable contraception; however, barriers to access remain.[37-39] Recently, a geographically and politically diverse group of states has been experimenting with policies to expand access to contraception.[i] Policies mandating insurance coverage of a 12-month supply contraception at one prescription fill may enhance contraceptive continuation by alleviating difficulties traveling to a pharmacy several times a year.[40,41] Policies to permit pharmacist prescribing of contraception may facilitate access by reducing difficulty finding or getting an appointment with a clinician.[42] However, extant work has shown mixed results on the effect of individual state policies on realized access to contraception, largely due to variation in implementation of and funding for such policy efforts.[43-47] The Food and Drug Administration is currently considering approving sales of over-the-counter hormonal contraception. More research is needed to understand how these contraception access policies might impact undesired pregnancy and abortion.

Conclusion

[i] Pennsylvania has not yet adopted these policies. More information about state contraception policies and potential impacts in Pennsylvania can be found here: https://www.converge.pitt.edu/sites/default/files/assets/Research%20Brief.pdf and here: https://www.converge.pitt.edu/sites/default/files/assets/12-Month%20Research%20Brief%20(1)%20(1).pdf

Reproductive autonomy – the ability to make and execute decisions about whether, when, and under what circumstances to become pregnant or parent in a way that is free from coercion – has been acknowledged globally as a fundamental human right.[48-50] Access to abortion care is just one part of reproductive autonomy, which is shaped by a broad array of social constructs, health and economic policies, reproductive healthcare services, and interpersonal factors.[51-53] In summary, the weight of the public health evidence suggests that legal abortion care is safe and that arbitrary restrictions on access to desired abortion 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."[54]

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