Joint House and Senate Democratic Policy Committee Hearing

A Post-Roe Pennsylvania
Thursday, Aug. 11, 2022 | 10 a.m. – noon
Hearing requested by the Women's Health Caucus

Wifi "Chatham Guest"

10 a.m.	Opening remarks: Co-chairs Rep. Dan Frankel and Sen. Katie Muth.
PANEL ONE	
10:10 a.m.	Dr. Sheila Ramgopal (they, them) MD, MA, FACOG, CEO
	Allegheny Reproductive Health Center
	Sydney Etheredge (she, her) MPH, President/CEO
	Planned Parenthood of Western PA
	Nicole Molinaro (she, her) MA, President/CEO
	Women's Center and Shelter of Greater Pittsburgh

Q&A with legislators

PANEL TWO

11:00 a.m. Sue Frietsche (she, her) founder/director

Western PA Women's Law Project

Dr. Marian Jarlenski (she, they) PhD, MPH, Assoc. Professor of Health Policy and Management, Associate Director of the Center for Innovative Research on Gender Health Equity

University of Pittsburgh School of Public Health

La'Tasha D. Mayes (she, her) MSPPM, founder

New Voices for Reproductive Justice

Q & A with legislators

11:50 a.m. Closing remarks: Rep. Frankel and Sen. Muth.

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August 10, 2022

Women's Health Caucus
Pennsylvania State House Legislature

Re: PA House testimony regarding the public health harms of limiting access to abortion care

To whom it may concern,

My name is Dr. Sheila Ramgopal. I am a board certified obstetrician and gynecologist who has practiced in Pennsylvania for 18 years. I practice obstetrics (deliver babies), provide hysterectomies and tubal ligations, provide gynecologic care (such as treating fibroids, abnormal bleeding, and endometriosis), provide all types of contraception and provide abortion services, I am also the Chief Executive Officer of Allegheny Reproductive Health Center (ARHC), which is an independent practice that serves primarily a free standing abortion facility since 1975.

As of June 24, 2022 when federal protection for abortion access were lost, ARHC saw a drastic increase in out of state clients seeking abortion services, especially from Ohio and West Virginia. Prior to this date, we saw about 30% of clients from surrounding states. Since this date, we are serving 60% of clients from other states. In 2021, we served about 3,300 clients seeking abortion services. We estimate that we will be serving about 6,000 clients in 2022, and likely 8,000 clients in 2023. The impact of the large influx of clients from other states has also impacted your Western Pennsylvania constituents who have to wait longer or travel outside of our region to access abortion to avoid longer wait times to obtain services.

The tremendous impact that abortion bans and restrictions have had on our community is profound. There are many studies that have shown that lack of access to safe abortion services has a detrimental effect on people with unwanted pregnancies, on their families and current children, and on overall community health. The effects are extensive with worsening health risks, financial impact, educational delays, increased rates of pregnancy related complications,

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increased rates of preterm birth and neonatal deaths, and higher rates of failure to thrive for children in these families.

Our public healthcare system in the state of Pennsylvania and in this country are already unable to improve the unacceptably high rates of pregnancy related mortality, and neonatal and child mortality, especially for communities of color and economically challenged groups. We have seen the downstream effects of drastic abortion bans in states such as Texas. We can see the widespread repercussions of people not being able to choose how and when to build their families when these bans go into effect.

Pregnant people who continue unwanted pregnancies have higher rates of preterm birth, fetal and neonatal demise, preeclampsia, postpartum depression, and many other complications. We know that abortion is ten to one hundred times safer than a full term pregnancy. Then we layer on the stress and impact of lack of access to abortion. We will be seeing many more people dying of childbirth related causes, postpartum and antepartum suicide, more neonates and young children dying … with a seriously disproportionate effect of communities of color.

On the opposite end of the spectrum, when we protect abortion access, we have seen the impact of people being empowered to have bodily autonomy and access to basic human rights - access to comprehensive reproductive health care including abortion allows families and individuals to thrive and this build stronger, healthier communities.

The impact of these abortion bans is not only on the health of people and communities. We cannot ignore the financial impact of losing access to abortion both for individuals, their communities, the healthcare system, and governmental entities. When abortion access is removed, people will still access abortion yet those abortions are often less safe, at higher gestational ages and done without easy access to medical care in an emergency. The people who have complications will have longer hospital stays, longer time away from work and their families, and often they are underinsured leading to astounding medical debt and liability.

The strain that removing abortion access in our state will have on Pennsylvania constituents, the community, and the entire system is completely unacceptable and completely preventable. If you look at the history of this country prior to federal protection of abortion access, hospitals and clinics were inundated daily by people with complications resulting from illegal abortions. The majority of those people were those who had financial limitations, young people, and folks of color. We will see this again in Pennsylvania if we do not protect abortion access in this state.

We need to be a model for serving our community and move beyond the politicized rhetoric of “pro-choice” and “pro-life”. I urge you to actually re-humanize the topic of abortion, I urge you to

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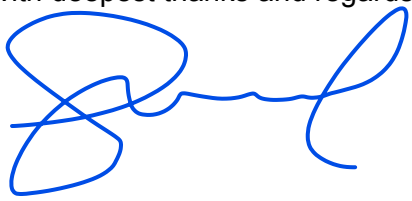
speak with your own friends and family. You definitely know someone and care about someone who has had an abortion. Would you want your loved ones, your children, your spouse, your sibling to be forced to continue a pregnancy that they are not ready for … whatever their reason may be?

As someone who has worked in Pennsylvania for almost two decades, who has served this community and centered marginalized communities in our work - I know that it is possible to do better for Pennsylvanians. We know that models of care that are person centered and support bodily autonomy yield the best outcomes. We know that equitable access to healthcare supports individuals, families and communities. We also know that access to safe and legal abortion supports people to thrive, families to be strong and communities to be resilient.

I would love to speak with anyone who has more questions or would like to discuss these topics further. We also have many Pennsylvanians who have had abortions who would be willing to submit their testimony on the impact of having abortion access available in our state has had on their lives. This is just the beginning of this conversation and we have much more work to do to continue to support Pennsylvania citizens and make this state safer for anyone needing abortion services in our state.

With deepest thanks and regards,



Sheila Ramgopal, MD, MA, FACOG

Sydney Eheredge
President/CEO Planned Parenthood of Western Pennsylvania
Testimony: Joint Policy Hearing Aug. 11, 2022

Good morning. My name is Sydney Etheredge, I am the President and CEO of Planned Parenthood of Western Pennsylvania. Thank you to the members and the committee for inviting me here today.

I am here today on behalf of the dedicated staff, supporters, and nearly 6,500 patients who access sexual and reproductive health care at Planned Parenthood of Western Pennsylvania

Seven weeks have passed since the Supreme Court made history by overruling almost 50 years of precedent and overturning Roe v. Wade. In doing this, the court stripped nearly half the population of a federally guaranteed right to abortion and put medical decision-making into the hands of lawmakers and politicians. Abortion is time sensitive and essential, it is life-saving and it is a decision that belongs to the pregnant person.

As expected, our region has seen the effects of this decision almost instantly with the only two freestanding abortion clinics, Allegheny Reproductive Health Center and Planned Parenthood of Western Pennsylvania, taking on an influx of patient calls and visits. Despite the strain, this has put on our centers–not to mention the challenges travel and other barriers can put on patients–our staff continues to do all they can to ensure that patients get the care they need when they need it. While abortion is still legal in Pennsylvania at this time, it is critically important that abortion remain accessible not just for Pennsylvanians, but for those coming to our state in search of compassionate care.

I want to be clear, restrictions on health care will never make a community healthier or better. With the lack of access to abortion, the consequences and health risks of forced pregnancy have sadly become apparent in states all over the country. Medicine has advanced, and abortion, even when self-managed, is overwhelmingly safe. However, the risk of serious pregnancy complications, including death, remains high. This is especially true for Black women who are four times more likely to die from pregnancy-related causes. Some experts predict that the dangerous combination of restrictive abortion laws, increased births, and insufficient access to care writ large could drive a further increase in the already unconscionable maternal mortality rate in the U.S. – and in Pennsylvania.

Even with all of this information being reported and readily available, Pennsylvania anti-abortion legislators passed an anti-abortion constitutional amendment in the middle of the night and behind our backs–without dialogue from advocates, providers, or patients. The outcome has left many of us outraged as the process of amending our state constitution is being used to threaten our most basic and fundamental right: health care. It is clear we are confronting the fight for our lives.

Every single person deserves access to the full range of sexual and reproductive health care without fear of violence. Providers deserve to deliver care without having to navigate medically unnecessary regulatory obstacles. Yet, Pennsylvania is one of the few access states that require patients to undergo medically unnecessary pre-procedure lab work before receiving a medication abortion. This lab work is not supported by experts in the field and creates yet another barrier to care. As more states push abortion restrictions and bans, patients will continue to look to Pennsylvania as an access point for care. With 85% of counties in the commonwealth without an abortion provider, only 17 clinics left in the state, and many providers still dealing with the impact of COVID-19 on our health care workforce, there is already so much we are all up against. To truly protect women and families, we need to repeal anti-abortion legislation, remove unnecessary restrictions, and push back on new harmful attempts to restrict care, all while working on expanding access to meet this critical need.

Planned Parenthood of Western Pennsylvania is always open to speaking with members about our work, and the ways we can work together to protect and expand access.

Women's Center & Shelter
of Greater Pittsburgh

PA House Democratic Policy Committee Policy Hearing on Post-Roe PA
August 11, 2022
Women's Center & Shelter remarks submitted and to be delivered by Nicole Molinaro, President/CEO

Good morning. My name is Nicole Molinaro and I am the President and CEO of Women's Center & Shelter of Greater Pittsburgh, one of the first six domestic violence (DV) programs in the country and a leading DV organization in our state. Each year, WC&S serves over 7,500 adult domestic violence survivors and their children, and we also facilitate a large, county-approved batterers intervention program serving those who use violence.

I am here on behalf of the millions of Pennsylvanians who, over their lifetimes, have been victims of domestic violence. This includes many who have experienced reproductive coercion and rape at the hands of their partners. These victims often don't have a voice in their own lives, never mind a voice in the legislative process. Thank you for thinking of and caring about them during this process.

You may be wondering where the number comes from that I just quoted of "millions" of victims in Pennsylvania. This is based on the CDC statistic that 1 out of every 4 women and 1 out of every 10 men have experienced serious abuse, sexual violence, or stalking in an intimate relationship. Extrapolating this to the current population of Pennsylvania (13 million), there are over three million domestic violence survivors currently living in our state. And specific to sexual abuse, in a nationally representative sample, researchers Stockman et al reported that approximately one out of every four women reported coerced sex. These staggering statistics speak for themselves.

Domestic violence, also called intimate partner violence, is more than physical or sexual violence. It's a pattern of power and coercive control that one person uses over their partner that is aimed at lowering the victim's self-esteem and safety. This pattern of abuse typically puts the victim in more and more danger over time. It may look like physical violence, sexual violence, emotional abuse, psychological abuse, financial abuse, or all of these at once, plus any number of other types of abuse. For this hearing's purpose, though, we are talking specifically about sexual violence as part of a pattern of coercive control.

Those who abuse their partners use a manipulative pattern of power and control – and they maintain power within their relationships by undermining their partners' economic security, health, safety, and autonomy. They often weaponize survivors' sexual and reproductive choices as tools of violence. Taking away victims' or survivors' right to choose whether or not to have a baby jeopardizes their mental and physical health – and in some cases, their lives – and perpetuates the cycle of violence.

Those who use abuse often escalate and become more violent when their partner becomes pregnant. Pregnancy significantly increases the risk of intimate partner homicide, which is the leading cause of death among pregnant and postpartum people. Abusers may also intentionally impregnate victims against their will to keep them trapped in the relationship. If a survivor is forced to give birth, the physical, emotional, and economic toll of pregnancy, childbirth, and raising a child can make it harder for

survivors to leave. Furthermore, a shared child creates a legal relationship between the abuser and the victim that is nearly impossible to sever, keeping the victim trapped in the cycle of violence for decades.

So, what do the numbers say?

- Domestic violence is more common than any other health problem during pregnancy.
- Nearly 20% of pregnant people experience violence during pregnancy, with pregnant adolescents and those with unintended pregnancies at an increased risk.
- 1 in 6 cases of abuse start while the victim is pregnant.
- Lack of access to abortion care has a disproportionate impact on low-income people, Black people and other people of color, transgender and non-binary people who can get pregnant, rural communities, people with limited English proficiency, people with disabilities, and others who already struggle to access healthcare.

At Women's Center & Shelter of Greater Pittsburgh and in domestic violence programs across the state and country, we see the destructive impact and traumatic aftermath of abuse every single day. We hear the most private details of people's lives; and yet, survivors we've developed deep relationships with often only disclose they've been sexually abused when they trust us enough to feel safe to do so, which is sometimes months into the professional relationship. When we name "reproductive coercion," most of our clients know exactly what it is because they've experienced it, but, powerfully, they haven't realized it's so common that it is actually named and studied. And although no two survivors – or their stories – are the same, it is quite common for a survivor to tell us they experienced the first instance of abuse or more severe abuse while they were pregnant.

So who am I here on behalf of? I am here on behalf of Anne, whose partner raped her repeatedly and sabotaged her birth control throughout their marriage, resulting in pregnancy after pregnancy. When Anne was finally able to escape and reach out for our help, she had 7 children under the age of 8, and she had just discovered she was pregnant with her 8th child. She had complex medical problems caused by the repeated pregnancies in quick succession and from the physical injuries, including traumatic brain injuries, that she had endured over the years. She was exhausted, her self-esteem was non-existent, she had no money of her own, and she hadn't felt safe in her own home in longer than she could remember. Anne's life was at risk carrying the baby, due to both the violence and the damage to her own body from past pregnancies. She felt unable to care for herself, her children, and her current pregnancy. She knew the only way for her to live – and for her 7 young children to live – was to leave, and she dug deep for the bravery to do so. Anne got an abortion as soon as she was able. This courageous act of survival, of exercising her right to choose, allowed Anne to hit re-set on her life. She was able to start re-building a life free from violence for her 7 young children and herself. It has been a long road for Anne, and her journey has been difficult, but finally harnessing her right to choose to not have an eighth child, another child conceived of rape and violence, made all the difference for her and her children.

I'm also here on behalf of Shayla, a domestic violence survivor who was pregnant as a result of forced prostitution by her abusive partner. Shayla required a therapeutic termination of her pregnancy; this means there was a medical necessity to induce abortion because Shayla was at risk of substantial harm, and her pregnancy was unviable. Shayla's life was at risk if she didn't have an abortion. Her life was saved by receiving this urgent medical care from a reputable provider, financial help, and support from an empathetic advocate. The abortion kept Shayla medically safe, as well as helped her to take the first step toward physical and emotional safety from her abuser.

It can be remarkably difficult to overcome the numerous barriers to leave an abusive relationship, regardless of the circumstances. Add to the logistic and emotional barriers that leaving is the most dangerous time for a survivor, with 73% of those who are killed being killed when they try to leave or after they've left. And add to this when a survivor is pregnant; taking away their right to choose often also takes away the ability for a victim to safely leave their abuser and create a new life for themselves. When survivors are able to choose for themselves whether to continue a pregnancy that was conceived using manipulation, fear, and violence, and when they have access to safe and legal abortion if they choose to not continue the pregnancy, it protects victims and survivors of domestic violence, both at the time of pregnancy and for years to come. Access to reproductive healthcare can be nothing short of lifesaving for the many victims of domestic violence who are trying to live their lives free from abuse.

Everyone deserves to live free from abuse and violence. Thank you for your time and consideration of how reproductive choice greatly impacts such a vulnerable population, now and into the future.

Comments Submitted in Response to the August 11, 2022 Hearing: "A Post-Roe Pennsylvania"

Chairman Bizzarro and Members of the House Democratic Policy Committee:

My name is Marian Jarlenski, and I am 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

[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.

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 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, there is no robust evidence that access to legal, desired abortion care is harmful to health. In contrast, the available evidence suggests that being denied a wanted abortion has negative health consequences in the short-term, but longer-term trajectories of health between people who did and did not

[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

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 SMM and death. One study estimated that pre-*Dobbs* state abortion restrictions were associated between a 2% and 12% increase in maternal mortality.[26] Evidence is only just starting to emerge 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 health insurance coverage 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 employer-sponsored insurance coverage, and other private insurance coverage of abortion care and related travel for care, affects health outcomes.

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[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.

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

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,

[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 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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UPMC
LIFE CHANGING MEDICINE

Post-Roe Pennsylvania Hearing

House and Senate Democratic Policy Committees

August 11, 2022

Testimony Submitted by the University of Pittsburgh Medical Center

UPMC would like to thank members of the Senate and House Democratic Policy Committees and Women's Health Caucus for allowing us to provide written testimony on Post-Roe Pennsylvania. Thank you for holding this important conversation as we grapple with what the recent Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* means for our patients, Health Plan members, health care providers, and staff.

Headquartered in Pittsburgh, UPMC is a world-renowned health care provider and insurer. We are an international health care leader — pioneering groundbreaking research, treatments, and clinical care. UPMC operates 40 hospitals and more than 700 doctors' offices and outpatient centers with locations in western and central Pennsylvania, Maryland, New York, and around the globe. As part of our health care delivery system, UPMC is a world-class provider of pregnancy and reproductive health.

We recognize that this is a time of confusion and anxiety for many, and reproductive rights are a highly personal issue. We all share the same goal of ensuring excellent, compassionate care for every patient. UPMC is committed to treating every patient with dignity and empowering them through a shared decision-making approach to evidence-based comprehensive reproductive health care.

Many of the patients our teams care for experience medical and pregnancy complications that make ongoing pregnancy and giving birth dangerous. For a portion of these patients, intervention is needed to prevent severe maternal morbidity and mortality. UPMC remains committed to providing the full continuum of women's health services, including safe patient-centric reproductive care, in accordance with all applicable laws and with the highest ethical and medical standards.

As this issue evolves, UPMC remains committed to engaging our clinicians and other experts to develop the clinical protocols necessary to continue supporting our patients and staff.

We respect the views and opinions shaping this debate, and as a leading health care provider and insurer, UPMC will do everything possible to continue promoting access to high-quality, evidence-based reproductive care for all patients and members that we serve.

Again, we wish to thank you for allowing us to provide testimony on this critical issue.