Name: Buckley, Karen
Submission Date: 8/31/2023
Agency: Department of Public Health
Subject: Abortions
Tracking Number: PR2022-042

Please see attached comments from the Connecticut Hospital Association.
Thank you.

CONNECTICUT HOSPITAL ASSOCIATION

Connecticut Hospital Association Comments to Abortion Regulations

August 30, 2023

CHA appreciates the opportunity to comment on the Department of Public Health's (DPH) proposed abortion regulations. The proposed regulatory changes are necessary due to the rapidly changing abortion laws in Connecticut, and nationwide, in the aftermath of the United States Supreme Court overturning Roe v. Wade. The regulations should allow patients and providers to understand their rights and obligations and be written in a manner consistent with Connecticut's evolving statutory framework relating to abortion.

We understand that it may be difficult for DPH to adjust to the rapidly changing landscape while crafting regulations. Still, CHA is concerned that the proposed regulations do not capture the necessary changes, or scale of modernization relating to abortion as a healthcare service under Connecticut law. We urge DPH to take a closer look at the proposed regulations. Otherwise, there will likely need to be increasingly more corrective statutory intervention to retire these regulations and adequately protect patients and providers. To assist in that undertaking, we offer the following comments.

Proposed changes to Section 19-13-D54. Abortions.

With respect to Section 19-13-D54 the language should be revised for clarity, to align with current standards, and for accuracy (including medical accuracy). As drafted, the language also raises several important questions.

The following comments address those issues:

<u>CHA Comment #1</u> On Proposed Changes to 19-13-D54(a). Reporting Medication Abortions.

Subdivision (2) of subsection (a) of proposed 19-13-D54 defines "Medication abortion" as "a termination of a pregnancy using pharmacological agents." Medication abortions historically were performed within the physical confines of a healthcare setting, often with specific medical observation. In modern times, that is often not the case. Patients more and more will be prescribed medication that will induce an abortion outside of a physical healthcare setting, and outside of the observation of a healthcare provider.

The draft regulations go on at proposed subsection (c) of 19-13-D54 to require detailed reporting by a healthcare provider for "all abortions." This language is insufficient to instruct providers on what reporting (if any) is required for medication abortions that will occur outside of a healthcare setting. Further, if reporting of a medication abortion prescription is required, what is the plan for not overcounting (or undercounting) the details of provided abortions?

We urge DPH to clarify a healthcare provider's reporting obligations specific to medication abortions that occur outside of a healthcare setting.

CHA Comment #2 On Proposed Changes to 19-13-D54(c). DPH Use Of Reported Information.

Subsection (c) of proposed 19-13-D54 deletes language that previously restricted DPH's use of reported abortion information "only for statistical purposes" except in licensure cases. The proposed language implies that there may be other uses, and that the reported data may not be held confidentially "in cases involving licensure."

Why has the restriction been removed? What is the enabling statute that allows other uses of the abortion information? What are those uses intended to be beyond statistical purposes (or licensure cases)?

CHA Comment #3 On Proposed Changes to 19-13-D54(c). Revisions To Reported Information.

Subsection (c) of proposed 19-13-D54 updates the list of reporting details for "all abortions."

These details include the type of "facility" where the abortion was performed, and the type of healthcare provider who performed the abortion. As discussed in Comment #1, these are not possible to report for prescribed medication abortions where the medication may be taken at home or in another location that is not a healthcare facility.

CHA Comment #4 On Proposed Changes to 19-13-D54(c). Revisions To Reported Information.

Subsection (c) of proposed 19-13-D54 updates the list of reporting details for "all abortions."

The subsection deletes the previous two (2) year destruction schedule, substituting instead that the records will be destroyed (not in two years but) "in accord with applicable record retention law and schedules."

What is that schedule? And has DPH considered the privacy and patient risk implications of maintaining these reports longer than absolutely necessary given the nationwide environment that, in many places, is hostile to patients who seek, and healthcare providers who participate in, providing abortion as healthcare?

Extending the retention period is particularly concerning where DPH intends to collect the state of residence for each patient, despite the many states that consider it a crime to travel to Connecticut for abortion as healthcare.

CHA Comment #5 On Proposed Changes to 19-13-D54(e). Revisions To Standards.

Subsection (d) of proposed 19-13-D54 updates the required "standards to control the quality of medical care provided to patients having abortions."

This subsection, by its own language, is directed specifically to "outpatient clinics operated by corporations and municipalities."

Question: Does it apply to hospitals?

CHA Comment #6 On Proposed Changes to 19-13-D54(h). Language Modernization Needed.

To the extent the list of requirements designated as "standards to control and quality of care" apply to hospitals or hospital services, CHA asserts that the lists in proposed subsection (e) are outdated and do not reflect current recognition of abortion as healthcare. Abortion as healthcare should not be singled out as something other than treatment or patient care. While we do not object to the reference to the American College of Obstetricians and Gynecologists, the regulation should also reference "The Society of Family Planning," which is the accredited academic specialty for abortion and contraceptive care for Ob-Gyn residency graduates. Additionally, the prevailing standard of care, including medical experience and judgment, should dictate for example, what treatments, pre-tests, physical examinations, or pathology are appropriate.

CHA Comment #7 On Proposed Changes to 19-13-D54(g). Moral And Religious Objections.

What is the statutory basis for the proposed regulatory language that would allow providers to choose not to participate in the performance of an abortion as healthcare based on the provider's beliefs?

CHA Comment #8 On Proposed Changes to 19-13-D54(h). Language Revision Needed.

Proposed subsection (h) uses the term "newborn" in the phrase "if the newborn shows signs of life" even though that is not consistent with current terminology, or other parts of the existing regulation, which use the correct terminology which is "fetus."

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Proposed changes to Section 19a-116-1. Abortion Services In Outpatient Clinics

With respect to Section 19a-116-1, the language needs to be revised for clarity, to align with current standards, and for accuracy (including medical accuracy). As drafted the language also raises several important questions.

The following comments address those issues:

CHA Comment #1 On Proposed Changes to 19a-116-1. Institutions Affected.

The title of the regulatory section is "Abortion Services In Outpatient Clinics." The preamble clause is directed to "outpatient clinics which offer abortion services." Several sections specifically indicate these regulations are for "clinics."

Question: Is this section applicable to hospitals and/or clinics operated under a hospital's license? CHA asserts that these are not applicable to hospitals or to services performed by a hospital. Hospitals already have significant parameters, obligations, standards, oversight, and rules that inform all patient care services. Abortion in Connecticut is healthcare. Hospital abortion services should not be singled out as "other than" healthcare services.

For example, subdivision (9) directs a written discharge summary be provided, with specific details. Hospitals already have obligations for discharge planning and summaries in both state and federal law. This directive is both confusing and unnecessary for hospitals. Another example: subsection (h) discusses "emergency preparedness" in terms that would be remedial for hospitals.

CHA Comment #2 On Proposed Changes to 19a-116-1(c). Language Modernization Needed.

To the extent the list of requirements designated as "standards to control and quality of care" apply to hospitals or hospital services, CHA asserts that the lists in proposed subsection (c) are outdated and do not reflect current recognition of abortion as healthcare. Abortion as healthcare should not be singled out as something other than treatment or patient care. While we do not object to the reference to the American College of Obstetricians and Gynecologists at this time, the prevailing standard of care, including medical experience and judgment, should dictate for example, what treatments, pre-tests, physical examinations, or pathology are appropriate.

CHA Comment #3 On Proposed Changes to 19a-116-1(d). Informed Consent.

To the extent that the provisions of 19a-116-1 apply to hospitals or hospital services, the informed consent portion is outdated with respect to language services. If an interpreter is used, the regulation requires the interpreter to "sign and date" the informed consent.

What is the statutory basis for the regulatory requirement that interpreters sign off before an abortion as healthcare is permitted to go forward?

Regardless of the setting in which the abortion is performed, we urge DPH to clarify that the interpreter's sign off can be captured remotely either (1) electronically, or (2) through attestation by the healthcare provider performing the abortion. Otherwise, this requirement is a *de facto* interference with the access to abortion as healthcare in Connecticut.

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Statement of Purpose.

We note that there is a scrivener's error in the Statement of Purpose that should be corrected.

The term "physician's assistant" should be "physician assistant."

Name: Sutocky, Roxanne
Submission Date: 8/31/2023
Agency: Department of Public Health
Subject: Abortions
Tracking Number: PR2022-042

Hartford GYN Center (HGC) appreciates the opportunity to comment on the Department of Public Health (DPH) proposal to change Public Health Code sections 19-13-D54 and 19a-116-1.

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August 31, 2023

Manisha Juthani, MD, Commissioner of Public Health
Connecticut Department of Public Health
410 Capitol Avenue, PO Box 340308
Hartford, CT 06134

RE: Proposed Regulations 19-13-D54, 19a-116-1

Dear Commissioner Juthani,

Hartford GYN Center (HGC) appreciates the opportunity to comment on the Department of Public Health (DPH) proposal to change Public Health Code sections 19-13-D54 and 19a-116-1. HGC is aligned with DPH's decision to update the state's current abortion regulations, which have not been substantively amended in decades, and we urge the Department to rescind the existing regulation in its entirety in favor of an integrated approach that includes abortion care within health care regulation of general applicability.

As specialists in the provision of first and second trimester abortion care for over 45 years, HGC is dedicated to providing the highest level of abortion care and reproductive health services, particularly for those facing the most significant barriers and for those who need care later in pregnancy. We know all too well that when abortion is restricted, the harm falls hardest on communities of color, immigrants, LGBTQ+ communities, young people and people working to make ends meet. The Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* has created a national public health crisis, and we are grateful that the state of Connecticut is committed fighting to keep abortion care safe, legal, and accessible.

After fifty years of legal abortion practice in the United States, we have a robust body of research on the extraordinary safety and efficacy of abortion and the negative impact of abortion restrictions on people's socioeconomic circumstances, health, and well-being. Abortion in all forms is a safe and effective procedure and can be performed safely in an office setting, with no special equipment or emergency arrangements.[1] Conversely, the economic, educational, and physical and mental health consequences of being denied a wanted abortion have been thoroughly documented in the landmark Turnaway Study.[2]

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[1] National Academies of Sciences, Engineering, and Medicine. *The Safety and Quality of Abortion Care in the United States.* (2018)

[2] Diane Greene Foster, et al., Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United States, 108 Am. J. Public Health 407 (2018).

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The restriction of abortion has long been misused as a method of "protecting" people seeking abortions. Today we know that abortion restrictions, whether they exist in statue, regulation, or practice, only serve to stigmatize and burden those seeking and providing abortion care. Unnecessary regulations on abortion care go beyond the accepted standards of care in the absence of evidence that they improve patient safety.[3]

Connecticut has taken significant steps, historically and recently, to secure reproductive rights and ensure practical access to care for all. Eliminating medically unfounded regulation that singles out abortion for disparate treatment is a logical and necessary next step toward ensuring equitable access to care, and similar restrictive regulations are being challenged or revisited in states across the country. In 2021, the New Jersey Board of Medical Examiners moved to end abortion exceptionalism opting instead to regulate abortion care within the general medical code.[4] The Board concluded the "restrictions in Rule 4.2 are medically unnecessary, do not protect patients' health or safety, and restrict access to abortion care in New Jersey." This year Rhode Island removed their Termination of Pregnancy regulations, which included provisions like Connecticut's current regulation, including requirements to report all abortions to the state's Department of Health and compel RH- testing regardless of medical indication.[5]

As a healthcare facility licensed in Connecticut, our facility, clinical operations and practitioners are currently regulated and overseen by multiple regulatory bodies, including the Department of Health. Our practitioners meet requirements for expertise and licensure in their field and are supervised by state licensing bodies and their Professional Boards. At HGC, we support regulation and licensure requirements that promote and protect patient safety and are in accordance with research informed standards of care and current scientific evidence.

Each regulation that is medically unnecessary forms part of a complex web that creates needless obstacles and potential for harm. The patient surveillance requirement compels clinicians to ask questions beyond what is clinically relevant, undermining the trust essential to patient-provider relationships. The level of detail requested may stigmatize, expose or intimidate patients, particularly those who hold reasonable concern for criminalization based on their identity or place of residence. Each individual component of a healthcare visit, including counseling, clinical interventions, and tests

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[3] Berglas, Nancy F., et al. *The Effect of Facility Characteristics on Patient Safety, Patient Experience, and Service Availability for Procedures in Non-Hospital-Affiliated Outpatient Settings: A Systematic Review*, 13 PLoS One (2018).

[4] New Jersey to Expand Access to Reproductive Health Care and Repeal Outdated Restrictions through Unanimous Vote by State Board of Medical Examiners, https://www.njoag.gov/new-jersey-to-expand-access-to-reproductive-health-care-and-repeal-outdated-restrictions-through-unanimous-vote-by-state-board-of-medical-examiners/ (2021).

[5] 216-RICR- 20-10-6.4.1(B) (repealed July 13, 2023)

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should be determined by the presentation of the patient and the practitioner's informed medical judgement, not dictated by the state as prescribed in the regulation. Much of the regulation are essentially Targeted Regulation of Abortion Providers, imposing specific facility and clinical requirements on abortion without a medical justification. Standards of clinical care should be based on the evidence and what we know is that abortion is exceedingly safe and does not need to be directed as a specific specialty. These examples demonstrate the need for a full review and repeal of the abortion regulation in 19-13-D54 and 19a-116-1.

As proud providers of patient centered abortion care, our highest priority and goal is that all individuals can access high quality, respectful and compassionate healthcare. We know firsthand that the restrictions in our abortion regulations are unnecessary and complicate access to care for our patients. We encourage a comprehensive update of the regulation of abortion to allow for greater access to abortion care, particularly for communities already facing significant systemic, economic, and logistical barriers to healthcare.

We thank the Department for its attention and consideration of these comments. We welcome the opportunity to be of assistance updating Connecticut' regulations to come into accordance with current clinical practice and scientific evidence. If DPH has any questions or requires additional detail, please contact Curtiss Hannum at channum@thewomenscenters.com.

Sincerely,

Curtiss P.S. Hannum, MSN, CRNP
Senior Vice President

Roxanne Sutocky
Director of Public Affairs

Name: Moran, Polly
Submission Date: 8/31/2023
Agency: Department of Public Health
Subject: Abortions
Tracking Number: PR2022-042

Sending comments on proposal for new regulations for Policies ad Procedures Regarding Abortions

August 31, 2023
Commissioner of Public Health
Department of Public Health

Comments on the proposed regulations: **Policies and Procedures Regarding Abortions**

Dear Commissioner Juthani,

The Connecticut Affiliate of the American College of Nurse-Midwives (ACNM-CT) commends the Connecticut General Assembly for recognizing, with new legislation passed in 2022, that CNMs, APRNs and PAs may now perform both medical and first trimester abortion procedures. They join our professional organizations in recognizing that these fall within our core competencies and scope of practice. We thank the Department of Public Health for the opportunity to comment on the crucial update of the regulations regarding abortions. We know that the present regulations are no longer a reflection of what is being done clinically nor are they reflective of the growing consensus around the country as to what kinds of regulations should be in place. ACNM-CT agrees with the Governor and with the State Legislature that supporting access to abortion should be paramount, especially in light of the restrictions placed on abortion access beginning well before the impact of the Dobbs decision last year. We are proud to work in a state which recognizes that this medical procedure is safe, that it is part of the broad spectrum of reproductive health care that our patients have a right to access. The regulations should reflect these facts so we will continue with our progressive history providing the full range of reproductive health services to the residents of Connecticut.

The Connecticut Legislature, the Executive Branch, stated explicitly by the Governor, and the State's Attorney's office all agree on the importance of reproductive health, rights and abortion access. We are surprised that the proposed language around the updating of the regulation remains so steeped in over-regulation and unnecessary language. We feel that the regulation will not adequately recognize the evolution of medical innovation or current standards of care. We feel the new regulation will already be outdated and unhelpful, if not overly burdensome from the outset. The regulations seem unusually explicit and detailed in regards to a medical procedure; this is not the norm for other types of medical procedures. Also lost in the new regulation is the fact that many, if not most of our offices, are doing predominantly medical terminations that take place outside of our offices. Why do we, as a state, still feel the need to treat abortion as a separate entity? One does not see the same type of extensive lists, definitions, consents, etc., with other medical procedures. We work in clinics, practices and hospitals across Connecticut. As Certified Nurse-Midwives, we adhere to strict standards of care that guide our practice; we apply best practices within our well-defined scope of practice to provide excellent, complete, informed care to all our patients. In fact our license to practice Nurse-Midwifery in the state of Connecticut is predicated on our adherence to specific standards of care, provided by the American College of Nurse-Midwives. We strive to implement best practices rooted in research and guidelines from our professional organizations to provide the informed care that we pride ourselves on.

We hope that much of the verbiage of the old, outdated regulations will be eliminated. Lists of steps deemed necessary in the provision of care, tailored to the different forms of abortion seems redundant, dangerous and too closely aligned with over-regulation that restricts abortion in other parts of the country. Research drives best practices and safety. We need to ensure that the regulations reflect the fact that all of the providers providing abortion care in the appropriate setting, are doing so by adhering to recognized standards of care and abortion guidelines. In

Section 19-13-D54: Abortions: eliminating the list of standards enumerated 1 - 11 should be considered. Those providers participating in abortions in outpatient clinics or hospitals can develop the standards to control the quality of healthcare provided to patients based on pre-existing mechanisms to develop, implement, monitor, and change standards as appropriate to time and place based on professional protocols and best practices. The same should be considered for **Section 19a-116-1. Abortion services in outpatient clinics**. Letter (c) should be eliminated (numbers 1 - 10) for the same reasons. Including wording recognizing standards of care consistent with the national standards for those providing abortion care, should be sufficient. The section seen under the proposed updates as letter (d), **Informed consent**, is also unnecessary. Providing informed consent, shared-decision making, patient centered care and quality of care are central to all of health care and its providers. Informed consent is central in medical ethics and medical law. It doesn't need to be detailed in this updated abortion regulation. That is already part of Connecticut state law.

We are also confused as to the use of the term abortion clinic under **(g) Quality assurance and risk management**. Who exactly does that refer to? Is this for any space where abortions take place? Many providers work in clinics or offices where abortion is just one of many procedures, services or aspects of reproductive health that we provide. We are obligated by our license and by our professional organizations to document quality control, continue our education, and assess best practices. Since health care facilities already have in place these types of quality assurance and risk management programs, can the regulation just recognize this?

Again we are grateful for the steps the State of Connecticut is taking to ensure safe, legal and accessible abortions. The ACNM-CT Affiliate sees abortion care as an essential element of reproductive health care in accordance with the ACNM view that "everyone has the right to make reproductive health choices that meet their individual needs." Midwives who choose to do so are ideal abortion providers, and their services will help to improve access to abortion in the United States, especially for underserved populations. We hope that the final agreed upon regulations are truly updated to meet the needs of our patients and our practitioners. We do not need overly burdensome language when much of what we do, much of what the regulation and the authorities wish to do, is make sure that abortion, like all other health care services, is safe and complies with standards based on changing research and best practices. Please, let's make sure this is reflected in the updated **Policies and Procedures Regarding Abortions form the Connecticut Department of Public Health.**

Thank you for this opportunity,

Polly C. Moran, CNM, MSN
Legislative Liaison for ACNM-CT Affiliate
pollymoran@yahoo.com

Name: Schweitzer, Marie
Submission Date: 8/31/2023
Agency: Department of Public Health
Subject: Abortions
Tracking Number: PR2022-042

Please see attached file for comments.
Thank you!

Agency Proposing Regulation: Department of Public Health
Proposed Regulation Concerning: Abortions
Sections Affected: 19-13-D54, 19a-116-1
Tracking Number: PR2022-042
September 1, 2023

UConn Health appreciates the opportunity to submit comments regarding the Department of Public Health's proposed regulations concerning abortions, specifically Sections 19-12-D54, and 19a-116-1.

UConn Health supports the concerns and positions outlined in the comments submitted by the Connecticut Hospital Association regarding these proposed regulations.

We respectfully ask the Department to update these regulations in accordance with current standards for medical care and, in addition to the sections and points discussed by CHA, we would like to specifically point out the following section:

Sec 19-13-D54 Abortions

(5) *pre-treatment laboratory testing for blood Rh factor.*

- *Comment:* We encourage the Department to update these regulations in accordance with current standards for medical care. For example, pre-treatment laboratory testing for blood Rh factor is not needed for all patients seeking an abortion. Pre-treatment laboratory testing for blood group and Rh factor should be done as necessary; it is not standard of care to require this testing for all cases.

Thank you for bringing these proposed changes forward for discussion and review, and for the opportunity to provide input.

Name: Raffa, Gretchen
Submission Date: 8/31/2023
Agency: Department of Public Health
Subject: Abortions
Tracking Number: PR2022-042

Please see attached comment from PPSNE

Planned Parenthood
Care. No matter what.
Planned Parenthood of Southern New England

August 31, 2023

Manisha Juthani, MD, Commissioner of Public Health
Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134-0308

Submitted electronically via https://eregulations.ct.gov/

RE: Proposed regulations concerning: Abortions PR2022-042

Dear Commissioner Juthani,

Planned Parenthood of Southern New England (PPSNE) appreciates the opportunity to submit these comments regarding Connecticut Department of Public Health (DPH) proposed regulatory changes, published as PR2022-042. As a trusted sexual and reproductive health (SRH) care provider, educator, and advocate, we appreciate the opportunity to provide comments on how the proposed regulations can be further amended to better improve abortion access in Connecticut and more closely align with the medical standard of care and national needs, given the current abortion landscape in the United States.

PPSNE is a safety net provider for those in Connecticut who are most in need of health services. PPSNE operates 14 health centers across the state of Connecticut and serves as a leading health care provider of high-quality, affordable health care for all people. Our health centers range in size and location, with small rural clinics and large metropolitan locations. Every year, our health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for STIs, abortion, and other essential care to about 55,000 patients, many of whom would not be able to afford care elsewhere. About 50% of Planned Parenthood's patients use Medicaid coverage or other state-funded programs to access affordable care.

Between July 2022 and July 2023, PPSNE performed 9,791 abortions at Connecticut health centers. About 72% of people who receive abortion care with PPSNE do so via medication abortion. Since the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*,[1] PPSNE has seen a 59% increase in the number of patients traveling from states that have banned some or all abortion care.

[1] *Dobbs v. Jackson Women's Health Organization* (United States Supreme Court, June 24, 2022).

As the leading SRH care provider in Connecticut, PPSNE appreciates DPH's commitment to protecting and expanding access to abortion care for people who need it in our state. We fully agree with DPH that updating these abortion regulations is vital — Connecticut's current regulations are medically and operationally out of date and overly restrictive.

The Supreme Court's decision in *Dobbs* has dramatically changed the landscape for abortion access in our country. Following the decision, states have enacted a patchwork of abortion bans, with 22 states now banning or severely limiting abortion.[2] Before the *Dobbs* decision, Connecticut had a responsibility to provide access to health care, including abortion, to those in our state who needed it, but we must now strive for more. As Governor Lamont has made clear, "This is an issue of freedom," and we must do "everything in our ability to protect [] reproductive rights." This means ensuring our state's laws and policies are accurate, updated, and clearly aimed at protecting patient safety without placing any medically unnecessary limitations on access to reproductive health care. This includes updating our state's abortion regulations.

Abortion is a critical component of reproductive health care and a safe procedure with a low risk of complications — there is no justification for limitations on access to abortion that go beyond routine safety standards that exist for all health care services. It is important that abortion remain a safe and legal medical procedure for a patient to consider if or when they need it. Abortion is a critical component not just for a patient's health, but for their ability to lead a free and fulfilling life with dignity and autonomy.

Connecticut has every reason to want people in the state to be able to access abortion when they so choose. When abortion is not an option, women *and* children suffer — states with more abortion restrictions tend to have poorer health outcomes for women and children than other states, including higher rates of maternal and infant mortality.[3] Patients who are unable to access a wanted abortion are more likely to receive public assistance and lack full-time employment six months after being turned away.[4] These economic consequences impact individuals, their families, and their communities for years to come. A study published in January 2020 by the National Bureau of Economic Research found that when a woman is unable to secure an abortion she needs, it quadruples the odds of the new mother and her child living in poverty going forward.[5] Furthermore, in states where laws impede access to abortion or limit the number of abortion clinics, both women and men have a decreased likelihood of transitioning from

[2] Planned Parenthood Federation of America (PPFA). Internal Tracking as of August 1, 2023.
[3] *See* Ibis Reproductive Health & Ctr. for Reproductive Rights, Evaluating Priorities, Volume II 23 (2017), *available at* https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf.
[4] Diane Greene Foster, et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United States*, 108 Am. J. Public Health 407 (2018).
[5] Miller, Sarah, et al. The Economic Consequences of Being Denied an Abortion, NBER Working Paper, No. 26662 (January 2020), https://www.nber.org/papers/w26662.

unemployment to employment.[6] In contrast, when given access to abortion, women's health outcomes and economic security improve. Women living in states with policies that support access to reproductive health care have higher earnings and are more integrated into the workforce than women in other states.[7]

It is not only abortion bans that have negative impacts on pregnant people and their families. In July 2022, in direct response to the Supreme Court's decision overturning *Roe v. Wade*, more than 75 health care organizations, including the American Medical Association, the American Academy of Family Physicians, the American Academy of Nursing, the American Academy of Pediatrics, the American Board of Internal Medicine, and the Society for Maternal-Fetal Medicine, issued a statement condemning "all legislative interference in the patient–clinician relationship."[8] The collection of expert groups stated that "Our patients need to be able to access — and our clinicians need to be able to provide — the evidence-based care that is right for them, including abortion, without arbitrary limitations, without threats, and without harm."[9] This statement from the nation's premier medical organizations and associations recognized that abortion bans "impair the integrity of the medical profession" and "have a devastating and unquantifiable impact on the patients and clinicians."[10]

Legal restrictions on accessing abortion that go beyond those placed on all other medical care are medically unnecessary. There simply is no reason to over-regulate abortion. Abortion is an exceedingly safe medical procedure and a critical component of reproductive health care. In fact, abortion is one of the safest medical procedures offered in the United States, with a proven safety record, with over 99% of abortions resulting in no significant complications. The abortion-related mortality rate is lower than that for colonoscopies, plastic surgery, dental procedures, and adult tonsillectomies.[11] For medication abortion, which accounts for the majority of abortions in our state, serious adverse events are exceedingly rare, generally far below 0.1% for any

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[6] Kate Bahn et al., *Linking Reproductive Health Care Access to Labor Market Opportunities for Women*, Ctr. for Amer. Progress (Nov. 21, 2017, 9:01 AM), https://www.americanprogress.org/issues/women/reports/2017/11/21/442653/linking-reproductive-health-care-access-labor-market-opportunities-women/.

[7] Kate Bahn et al., Ctr. for Am. Progress, *Linking Reproductive Health Care Access to Labor Market Opportunities for Women* (2017), *available at* https://www.americanprogress.org/issues/women/reports/2017/11/21/442653/linking-reproductive-health-care-access-labor-market-opportunities-women/. *See also* Asha Banerjee, Economic Policy Institute, "The economics of abortion bans," January 18, 2023, https://www.epi.org/publication/economics-of-abortion-bans/ ("While the effect of abortion denial is overwhelmingly negative economically, mentally, and physically, there is also strong evidence for the flip side of this argument: that access to abortion is associated with positive economic outcomes, including lower rates of teen births and teen marriages").

[8] ACOG et al., *More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference* (July 7, 2022), *available at* https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizations-release-joint-statement-in-opposition-to-legislative-interference.

[9] *Id.*

[10] *Id.*

[11] *See* Christopher E. Adams & Moshe Wald, *Risks and Complications of Vasectomy*, 36 Urologic Clinics N. Am. 331, 331 (2009); *see also* Tsuru Ranasinghe et al., *Differences in Colonoscopy Quality Among Facilities: Development of a Post-Colonoscopy Risk-Standardized Rate of Unplanned Hospital Visits*, 150 Gastroenterology 103, 109 (2016); Francois Blondeau & Nach G. Daniel, *Extraction of Impacted Mandibular Third Molars: Postoperative Complications and their Risk Factors*, 73 J. Canadian Dental Ass'n 325, 325b (2007); Jack L. Paradise et al., *Tonsillectomy and Adenotonsillectomy for Recurrent Throat Infection in Moderately Affected Children*, 110 Pediatrics 7, 12 (2002).

individual adverse event.[12] The most common form of procedural abortion performed in the first trimester of pregnancy is associated with roughly a 0.16% chance of major complications, and nationwide, less than 0.3% of abortion patients experience a complication that requires hospitalization.[13] The risk of death associated with childbirth is approximately 14 times higher than that with abortion.[14]

Despite this data, and despite the grave public health crisis posed by the abrupt loss of abortion access in large parts of the country, Connecticut regulates abortion more heavily than it does other medical procedures of similar risk, and Connecticut imposes outdated requirements for abortion providers and their facilities that mimic "Targeted Restrictions on Abortion Provider" laws (TRAP laws), which have been used by states hostile to abortion to regulate abortion out of existence.[15] In Connecticut, practitioners who provide abortions and clinics where abortions are provided are subject to heightened regulation, including additional reporting requirements, compared to other, similar health care providers. The regulations in our state single out abortion clinics for additional administrative, burdensome requirements — requirements that are wholly unrelated to patient health. Maintaining the provisions in Connecticut's current regulations would make us an outlier in the region, as our neighboring states have been striving to allow unburdened access to abortion for their residents and for those who are traveling for care by repealing unnecessary restrictions.[16]

PR2022-042 represents DPH's proposed update to Sec. 19-13-D54 and Sec. 19a-116-1. We appreciate DPH's commitment to expanding access to abortion and fully agree with DPH that these sections are overdue for an update, however, we believe the proposed rule does not go far enough in removing artificial, unnecessary restrictions on abortion and making clear to abortion

[12] FDA, Ctr. for Drug Evaluation & Rsch., Med. Rev., Application No. 020687Orig1s020, 47 (2016), https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf.
[13] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015); *see also* Ushma D. Upadhyay et al., *Abortion-Related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16 BMC Med. 1, 1 (2018).
[14] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012); Nat'l Acads. Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 1, 77 (2018), available at http://nap.edu/24950.
[15] In the years following the 1992 U.S. Supreme Court decision in *Planned Parenthood v. Casey*, opponents of safe and legal abortion advanced a wide array of legislation that included health care restrictions applicable to only abortion providers. These Targeted Restrictions of Abortion Providers, or "TRAP" laws, can include both facility and provider requirements. One type of TRAP law requires abortion facilities to comply with state laws that are intended for facilities that perform more invasive and risky procedures and use higher levels of sedation than abortion. These requirements are medically unnecessary, provide no benefit to patients, and are politically motivated to restrict safe access to abortion. These laws actually have the perverse effect of restricting access to health care and can ultimately jeopardize patients' health. In June 2016, the Supreme Court issued a decision, *Whole Woman's Health v. Hellerstedt*, in which the Court recognized that such medically unnecessary facility requirements for abortion providers can pose an unconstitutional burden on a person's right to access abortion. However, after the decision in *Dobbs v. Jackson Women's Health Org.*, which ended the federal right to abortion, state legislatures have again turned to using TRAP laws to restrict access to abortion under the guise of "health care regulation." This claim is as false and misleading now as it ever was, and these laws remain dangerous and unnecessary.
[16] *See, e.g.*, MN SF 2995 (2023) (enacted); NY SB 240 (2019) (enacted); 216-RICR- 20-10-6.4.1(B) (repealed July 13, 2023); 53 N.J.R. 2013(a), amending N.J. Admin. Code § 13:35-4A.3.

providers how they can adapt their standards of care to their patient's needs while maintaining safety standards and remaining in compliance with Connecticut regulatory requirements.

No abortion-specific regulations are required to ensure that abortions are provided safely and in a medically appropriate manner, and accordingly, PPSNE requests that DPH strike Sec. 19-13-D54 and Sec. 19a-116-1 altogether.

If DPH does not strike Sec. 19-13-D54 and Sec. 19a-116-1, we would recommend combining the requirements into one regulation applicable to outpatient clinics to reduce duplication and conflicting specific requirements. There are also a number of changes we believe are needed in order to clarify the regulations and remove barriers to care, some of which we believe are of critical importance. Below, we explain these requests for amendment and denote those that are essential.

Proposed amendments to the regulatory requirements of Sec. 19-13-D54 and Sec. 19a-116-1 that PPSNE considers to be essential:

1. In Sec. 19-13-D54(c), requiring health care providers to report every abortion to the Commissioner of Public Health within seven days is unreasonable, burdensome, and out of line with other states. Connecticut's one-week turnaround time on abortion reporting is among the shortest state-mandated reporting timelines. We ask that the state-mandated abortion reporting requirement at Sec. 19-13-D54(c) be eliminated, but if these reporting requirements are maintained in some form, they should allow the provider to report annually or, at most, monthly. They should also require reporting of fewer categories of patient information.

   This proposal would align Connecticut's abortion reporting requirements more closely with those in other states. Earlier this year, Rhode Island removed its Termination of Pregnancy regulations, which included a requirement to report abortions to the Department of Health.[17] This is consistent with states like Maryland, New Jersey, and New York, none of which have reporting requirements. For states that do have reporting requirements, most have much longer timeframes for reporting. For example, Minnesota and Kansas collect data on an annual basis. Massachusetts and Nevada require regular reporting, but do not specify a timeframe within which the reports must be submitted. Many of the other states in which abortion remains legal require reporting on a monthly basis; Maine and Illinois require that abortion reporting be submitted within 10 days of the end of the month within which the abortion was performed.

[17] 216-RICR- 20-10-6.4.1(B) (repealed July 13, 2023).

Some states have recently reviewed and reduced the information that abortion providers are required to report to the state. For example, Illinois enacted legislation this year to only track whether the patient was an Illinois resident or traveling from out of state, without tracking the states from which patients are traveling. Minnesota repealed many of the categories of its abortion reporting requirement, making abortion reporting less onerous for providers. This aligns with our request spelled out in more detail below that the state of patient residence need not be provided.

We acknowledge that reporting certain vital statistics information can be useful to furthering legitimate public health interests. However, collecting this granular level of detail about every abortion provided in Connecticut, and requiring it with such frequency and in such a short time frame, is not consistent with how other medical procedures are handled. It is burdensome on providers and threatens patient confidentiality. People should have the choice whether to share certain personal medical information and such involuntary disclosure should certainly not be mandated by the government.

2. In Sec. 19-13-D54(e)(1)-(11), stating "clinical standards of care shall include" is unclear, overbroad, and immensely burdensome on patients and providers. We believe that DPH intends this regulation to mean that providers should consider Sec. 19-13-D54(e)(1)-(11) as options for every patient, but only need to provide whichever of these interventions is medically necessary for the patient and method of abortion. We strongly believe DPH should make that discretion clear in the final rule. It is disadvantageous for administrators, patients, and providers to finalize these regulations with anything less than full clarity on this question. Ideally, the entirety of Sec. 19-13-D54(e)(1)-(11) would be struck. If DPH does not remove the list, which would leave clinical care standards up to the providers who are trained to provide safe, comprehensive medical care, we ask that the list be clearly and explicitly optional.

   To demonstrate the flaws with Sec. 19-13-D54(e)(1)-(11), we specifically want to explain the problems with including certain of these examples even as optional "standards of care" for abortion.

   a. Sec. 19-13-D54(e)(1) provides only a vague impression of what is required of providers, given there is no one way to verify a pregnancy. Most importantly, it is medically unnecessary to require this in regulation; when medically necessary, abortion providers will verify a patient's pregnancy before providing abortion care.
   b. Sec. 19-13-D54(e)(2-3) represent TRAP-style mandatory counseling and consent restrictions and are unnecessary. All providers already have a duty to obtain the informed consent of any patient (or that patient's legal representative) before

providing treatment under Connecticut law.[18] Even without these additional TRAP-like counseling and consent requirements, all providers, including abortion providers, could face legal liability and professional discipline for failing to meet their existing duty to obtain a patient's informed consent.[19] The proposed additional counseling and consent provisions wrongly imply that abortion providers alone require unique regulatory requirements in order to meet this basic standard of medical care.

c. The requirement in Sec. 19-13-D54(e)(4) that a pre-treatment history be collected is unnecessary, as providers always ask a patient or their representative about their relevant medical history as a part of routine standard medical care whenever possible. Sec. 19-13-D54(e)(4)'s physical examination requirement is also medically unnecessary because all providers, as part of routine abortion care, would confirm what type of abortion care is appropriate for a patient based on their medical history and, when medically appropriate prior to an in-clinic abortion, based on an examination.

d. Sec. 19-13-D54(e)(5) requires pre-abortion Rh testing. The current standard of care is that it is not medically indicated to routinely perform Rh testing prior to all abortions,[20] and Connecticut is one of only a small number of states that support access to abortion but that still require Rh testing prior to an abortion.[21] Research has shown that the risk of Rh sensitization after an early abortion is negligible, and that foregoing Rh typing and administration of anti-D immunoglobulin may be considered for patients with early pregnancies.[22] Absent other guidance, Connecticut's requirement could pose a medically unnecessary barrier to obtaining an abortion and is needlessly burdensome to providers and to patients, who may need to schedule a laboratory visit and have blood drawn without a medical indication.

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[18] *See e.g. Godwin v. Danbury Eye Physicians & Surgeons, P.C.*, 254 Conn. 131, 143 (2000), citing *Logan v. Greenwich Hospital Assn.*, 191 Conn. 282 (1983) (". . .we require a physician 'to provide the patient with the information which a reasonable patient would have found material for making a decision whether to embark upon a contemplated course of therapy.'"); *Sherwood v. Danbury Hosp.*, 278 Conn. 163, 180 (2006) ("the informed consent doctrine derives from the principle that every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.") (internal quotations omitted).

[19] *See* Conn. Gen. Stat. § 20-13c; Conn. Gen. Stat. § 52-184c.

[20] *See* National Abortion Federation, *2020 Clinical Policy Guidelines for Abortion Care*, at 10, available at https://prochoice.org/wp-content/uploads/2020_CPGs.pdf; *see also* Mark A, Foster AM, Grossman D, Prager SW, Reeves M, Velásquez CV, Winikoff B. Foregoing Rh testing and anti-D immunoglobulin for women presenting for early abortion: a recommendation from the National Abortion Federation's Clinical Policies Committee. Contraception. 2019 May;99(5):265-266.

[21] Only a small number of states support access to abortion and still require Rh testing for all abortions (Connecticut, Pennsylvania, Alaska, Montana, and Kansas), and Rhode Island recently repealed its Rh testing requirement. *See* 216-RICR- 20-10-6.3.3(D) (repealed July 13, 2023). Some other states that ban or severely restrict abortion access also require Rh testing for all abortions.

[22] In fact, research has shown the concentration of fetal red blood cells in first- trimester pregnant women undergoing uterine aspiration is below the calculated threshold for Rh sensitization. Horvath S, Tsao P, Huang ZY, Zhao L, Du Y, Sammel MD, Prak ETL, Schreiber CA. *The concentration of fetal red blood cells in first-trimester pregnant women undergoing uterine aspiration is below the calculated threshold for Rh sensitization*. Contraception. 2020 Jul;102(1):1-6.

e. Sec. 19-13-D54(e)(7) requires post-abortion tissue be sent to and examined by a pathologist. Connecticut is one of only three states that, as a default, requires pathology for certain pregnancy tissue absent a medical reason, and one of only two states (alongside Utah) that requires pathology for all pregnancy tissue.[23] Earlier this year, Rhode Island removed its pathology requirement as part of a broad repeal of outdated and unnecessary regulations on abortion care.[24] Requiring pathological examination following an abortion is burdensome for providers, stigmatizing and confusing for patients, and needlessly increases the costs of care. Absent a medical reason for ordering such pathology, these examinations are typically solely confirming that the tissue being examined is pregnancy tissue, when such confirmation is also routinely done by providers as they perform the procedure. In any cases where there is a medical or other indication for a pathological examination (e.g., in cases of a molar pregnancy), providers will order an examination, absent a regulatory requirement as part of the standard of care.

f. Sec. 19-13-D54(e)(8-9) mimics TRAP-type facility requirements that imply abortion clinics need separate and unique operating rooms and recovery rooms. This ignores the fact that the majority of abortions performed in our state are medication abortions where a patient is provided pills. No unique rooms beyond a waiting room and patient room are needed for medication abortion provided during an office visit, and providers are capable of assessing when and if a patient requires a different environment or resources, as they do for all other medical services. Such facility requirements are also inappropriate for medication abortion provided via telehealth. Moreover, these requirements ignore that in-clinic abortions are routinely and safely provided in examination rooms or in procedure rooms, and do not require the heightened environmental controls of operating rooms.[25] Providing in-clinic abortion safely only requires rooms that are adequate to accommodate the appropriate equipment and personnel involved in this non-invasive procedure.

g. Sec. 19-13-D54(e)(10) requires mandatory post-abortion counseling. Spelling out what pre- and post-treatment patient interactions abortion providers must engage in is a harmful form of abortion exceptionalism, and mandatory counseling requirements are a form of TRAP restriction used by hostile states to make the

[23] Utah requires that all pregnancy tissue following an abortion be examined by a pathologist. *See* U.C.A. § 76-7-309. Pennsylvania requires that all pregnancy tissue following an abortion after the first trimester be examined by a pathologist. *See* 18 Pa. Stat. and Cons. Stat. Ann. § 3214(c). An additional two states (Alabama and Missouri) that currently ban abortion had required pathology for pregnancy tissue following an abortion.

[24] 216-RICR- 20-10-6.3.3(F) (repealed July 13, 2023).

[25] *See generally* American College of Obstetricians and Gynecologists (ACOG), National Partnership for Women & Families, and the American College of Physicians, *Consensus Guidelines for Facilities Performing Outpatient Procedures Evidence Over Ideology*, 133 Obstetricians & Gynecologists 255, 255–60 (2019), DOI: 10.1097/AOG.0000000000003058. *See also* Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States*, at 162 (2018), https://doi.org/10.17226/24950.

abortion process more onerous. Such counseling requirements imply abortion providers aren't already meeting the standard of care and talking to patients about their outcomes, which is inaccurate, and these requirements imply abortion isn't safe or that patients may not have positive outcomes, which it is and they do. In fact, a 2019 study examining the emotional outcomes of patients who sought abortion found "no evidence of emerging negative emotions or abortion decision regret."[26] Instead, relief was the most commonly felt post-abortion emotion, and the overwhelming majority of patients reported that abortion was the right decision for them.

While we will not address Sec. 19a-116-1(c)(1-10) specifically, given those provisions are duplicative of the provisions addressed above, we are similarly concerned that Sec. 19a-116-1(c) duplicates the impression that certain interventions "shall" be provided without making clear that they are to be fully optional and discretionary. If DPH does not significantly strike or streamline these regulations and both sections continue to exist, we also ask that DPH amend the wording of Sec. 19a-116-1(c) to be clearly and explicitly optional.

3. In Sec. 19-13-D54(g), allowing any health care provider to refuse to participate in any phase of an abortion that violates the provider's judgment, philosophical, moral, or religious beliefs is an overly broad right to refusal that could have a negative impact on patient care. Freedom of religion is important; it's one of our nation's fundamental values. That's why it's already protected by the First Amendment to the Constitution, and already strongly protected by the state of Connecticut. However, religious freedom does not include the right to harm others. Religious or moral objections of health care providers or other health care facilities entities cannot be prioritized over patients receiving the care they need. Section 19-13-D54(g) is not limited to religious objections and allows refusals for philosophical and moral beliefs, or even just based on the provider's judgment. It also allows refusal for any phase of an abortion, which could imply that if a nurse disapproves of a patient for being unwed or for identifying as LGBTQ, the nurse could refuse to set up the patient room or collect a basic patient history if the patient is seeking an abortion. This type of broad refusal allowance is harmful for patients and unnecessary to protect valid religious rights of providers, and should be removed. If the provision is not removed, it should be narrowed to allow providers to opt out of providing abortions that violate their sincerely held religious beliefs.

[26] Corinne H. Rocca et al., *Emotions and Decision Rightness Over Five Years Following an Abortion: An Examination of Decision Difficulty and Abortion Stigma,* Soc. Sci. & Med. (2019), *available at* https://doi.org/10.1016/j.socscimed.2019.112704.

4. Sec. 19a-116-1(d)(2)(B)(ii) requires patient consent forms to be signed by any interpreter that is provided to a patient. Providers in Connecticut may not have the capability to comply with this. This requirement is potentially operationally impossible for providers like PPSNE who contract with interpreter service operators that connect interpreters into patient appointments via phone or video connections, but do not have interpreters physically present. If any providers in our state feel that they cannot offer virtual interpretation because of the operational challenges presented by this provision, that would have a negative impact on patient care. This requirement is also unnecessary for the health or safety of the patient. For these reasons, we ask that it be removed. If the requirement is not removed, we ask that DPH make clear that interpreters only need to sign patient forms if the interpreter is physically present.

5. Sec. 19a-116-1(f) has a grammatical error which makes its meaning unclear, and it should be amended. This section currently reads, "Counseling provided to the patient shall by the health care provider or a person who meets the definition of counselor in section 19a-600 of the General Statutes." Most importantly, as drafted, this provision could imply that counseling provided to all patients shall be performed by an authorized licensed provider or a person who meets the statutory definition of a counselor. Any such implication would go well beyond the statutory requirement in section 19a-601 of the General Statutes, which requires such licensure or counseling status only when a patient is a minor. We ask that DPH mirror the statutory requirement and not add on additional licensure requirements for counselors of adult patients, which would be medically unwarranted and burdensome on providers. DPH should make Sec. 19a-116-1(f) more clear by simply stating that any minor patients must be provided counseling in accordance with section 19a-601 of the General Statutes, or alternatively that "counseling provided to minor patients shall be provided by the health care provider or a person who meets the definition of counselor in section 19a-600 of the General Statutes."

6. Sec. 19a-116-1(g) refers to "all abortion clinics" and requires them to implement a written quality assurance and risk management program. The state of Connecticut does not license "abortion clinics" so it is not clear what providers would qualify as "abortion clinics" and need to comply with this provision. We ask that DPH clarify which facility licensure types this provision reaches.

Additional proposed amendments to the regulatory requirements of Sec. 19-13-D54 and Sec. 19a-116-1:

1. We ask that DPH change the definition of "health care provider" to mean "any provider authorized to perform abortion under C.G.S.A. § 19a-602," in both Sec. 19-13-D54 and Sec. 19a-116-1. We also ask that DPH then strike Sec. 19-13-D54(b) altogether. The proposed definition of "healthcare provider" and Sec. 19-13-D54(b) are unnecessarily

duplicative of C.G.S.A. § 19a-602(c)-(d). Repeating statutory provisions in regulation creates operational confusion and administrative hurdles if statutory law is amended. The regulations should merely refer to the existence of the statute defining which categories of licensed providers can perform abortion in the state and therefore must comply with the related regulations.

2. We ask that DPH not require reporting of "the patient's state of residence" in Sec. 19-13-D54(c). Requiring reporting of the state of residence is inappropriate and potentially compromises the confidentiality of patients who have traveled to Connecticut for care. While the name of a home state may seem broad enough that no individual could be identified, public records showing someone from a specific state got an abortion on a specific date could be used in an investigation or prosecution by states or actors hostile to abortion. That information could be coupled with other information that can be garnered about an individual – including data about when someone traveled to Connecticut or where they were within the state – to build a record against a patient, provider, or someone who helped a patient arrange their care. Instead, we ask that any required reporting only denote whether the patient was a resident of Connecticut or not.

3. We ask that DPH strike Sec. 19-13-D54(d) altogether. Limiting when certain procedures must be performed in clinics of various licensure categories is not routine or standard, and is especially inappropriate for a medical procedure as safe as abortion. Many states hostile to abortion have proposed or passed laws to require abortion to be performed in ambulatory surgical centers (ASCs) or hospitals, and these laws are not based on safety concerns, but are aimed only at limiting access to abortion. ASCs in our state must comply with a range of specific physical and environmental standards, including specific parking lot designs, hallway widths, recovery room structures, and plumbing and ventilation systems.[27] Such requirements contemplate creating a safe environment for complex, invasive surgeries and are medically inappropriate in the context of abortion procedures.

4. We request that DPH expand the listed organizations that can provide guidance for clinical standards of care beyond the American College of Obstetricians and Gynecologists (ACOG) in Sec. 19-13-D54(e). ACOG does not provide comprehensive standards of care for all aspects of medical care, and is a physician-led organization. To better align Sec. 19-13-D54(e) with the reality that non-physician providers can and do provide abortion in our state, we ask that it be broadened to be more inclusive and comprehensive. Therefore, we propose that Sec. 19-13-D54(e) could read: "All outpatient clinics operated by corporations or municipalities where abortions are performed shall develop standards to control the quality of medical care provided to patients having

[27] *See* Conn. Agencies Regs. 19-13-D56.

abortions. These standards shall be consistent with clinical guidelines put forth by relevant leading professional medical associations, including, but not limited to, the American College of Obstetricians and Gynecologists, the American College of Nurse-Midwives, the National Abortion Federation, and the Society of Family Planning. These standards shall be appropriate to the abortion methodology."

5. We request that DPH strike Sec. 19a-116-1(b) or amend the language. It is unclear what it means to require facilities, equipment, and care to "be consistent with the national standards of the American College of Obstetrics and Gynecology." It is not the role of ACOG to put forth standards for the maintenance, use, standards, processes and procedures for all facilities, equipment, and forms of health care. This is a broad, vague requirement with which it is effectively challenging for a provider to ensure compliance. If this section is to remain, it should be amended to read, "abortion providers shall take reasonable and appropriate care to maintain facilities and equipment up to safe medical standards."

6. In general, we believe DPH should strike any detailed requirements from Sec. 19-13-D54 and Sec. 19a-116-1 that providers secure informed consent. It is a core principle of medical ethics that all health care providers obtain informed consent before treating a patient, and at PPSNE, we always make sure that we have a patient's informed consent before initiating any treatment or procedure. If a patient is making the decision of whether to have an abortion, they will always obtain all the information necessary to give true informed consent to the procedure before it is performed — including how the process works, the range of normal outcomes to expect, and the warning signs to look for — as part of routine medical practice.

   Many states propose or enact "informed consent" laws or regulations aimed solely at abortion providers, which, at best, go far beyond the state's appropriate role in the provider-patient relationship and, at worst, attempt to shame people for their decision and provide them with inaccurate information. These laws and rules dictate what information a health care provider must give to a patient before they can have an abortion. As is the case in these proposed regulations, "informed consent" is a misnomer — instead these provisions single out abortion for disparate treatment and impose detailed requirements that have been co-opted as a way to dissuade patients from choosing to have an abortion.

   We believe that if DPH does not delete or significantly streamline the informed consent requirements in their proposed regulation, DPH should certainly strike Sec. 19a-116-1(d)(1)(C)(ii). It is redundant and unnecessary to require providers to fully describe "the discomforts and risks that may accompany or follow the performance of the abortion." This implies abortion patients routinely experience discomfort and risk and need to be

specifically warned about that. In reality, it is standard medical practice to tell patients what the potential outcomes or risks are before any procedure. Our state regulations should not perpetuate misinformation about abortion outcomes.

7. If DPH does not delete or significantly streamline the informed consent requirements in its proposed regulation, we also request that DPH amend Sec. 19a-116-1(C) to remove the requirement that certain information specifically be conveyed to patients *orally* prior to an abortion. Providers should be able to determine their preferred way of conveying information that is relevant to a patient's informed consent, and patients should be able to determine how to receive this information, whether in writing, orally, or otherwise. Oral communication is not appropriate or necessary for all patients receiving care, and this provision imposes a blanket requirement that does not take into account the diverse and specific needs of patients or their providers, including, but not limited to, patients who are deaf or hearing-impaired.

Planned Parenthood appreciates the Department's careful consideration of how our state can improve and expand access to abortion and updating the regulations concerning abortion. We urge the Department to incorporate our recommendations into the final abortion regulation to be consistent with the medical standard of care and clinical practice for abortion care. Should you have any questions about the issues discussed in this comment, please contact Gretchen Raffa at gretchen.raffa@ppsne.org. We welcome the opportunity to work with the Department on these recommendations.

Thank you for your consideration,

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