
Executive Summary

- Medication abortion is an important reproductive healthcare service.
 - Passage of Wisconsin Act 217 in 2012 increased regulation of medication abortion care in the state. The Act includes a requirement that the same physician who obtains consent from the patient must also administer the pills and watch the patient take them, as well as a ban on telemedicine for these services.
 - To assess the effect of Act 217 on patients and providers in Wisconsin, researchers at the University of Wisconsin-Madison conducted a study using in-depth interviews with Wisconsin physicians, nurses, and other healthcare professionals involved in abortion care.
 - The research team found that:
 - Providers unanimously expressed that current Wisconsin medication-abortion regulations harm both patients and providers.
 - Interviewees identified Act 217's same-physician provision as medically unnecessary, as burdensome for both patients and providers, and as the regulation most negatively affecting medication abortion care in the state.
 - Interviewees further described the same-physician restriction as vastly more obstructionist in conjunction with the 24-hour mandatory waiting period required for any abortion provided in Wisconsin. Providers underscored how these two restrictions work together to dramatically limit abortion access, especially for rural and low-income Wisconsinites.
 - Providers also emphasized that the ban on telemedicine for medication abortion services should be lifted in order to adhere to clinical best practices and to offer services to patients safely and remotely.
 - Taken together, the findings indicate that these providers resoundingly concur that Act 217 has undermined medication abortion provision and patient care.
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Medication Abortion Care and its Importance

Provision of medication abortion care is critical to ensuring access to safe and legal abortion overall. Medication abortion, which involves taking two pills, is a safe and effective method of pregnancy termination. When able to access both in-clinic (sometimes referred to as “surgical”) and medication abortion care, anywhere from one-third to over half of patients will select medication abortion as the mode that works best for them.^{1,2} Furthermore, medication abortion care can be administered safely through telemedicine, without necessitating in-person visits to a healthcare center.³ This telemedicine option is especially important in the time of COVID-19. Many patients want to avoid in-person health visits. Access to services via telemedicine is also valuable for rural residents and others who may have difficulty traveling to abortion healthcare facilities. Timely access to medication abortion is essential to ensuring meaningful, high quality abortion care.^{4,5}

Medication Abortion Care in Wisconsin

In Wisconsin, medication abortion access has become more restricted since 2012, when the Wisconsin State Legislature passed Act 217. Act 217 provisions include:

- It prohibits the use of telemedicine for abortion, even though research has documented the safety and efficacy of telemedicine for medication abortion services,^{3,6-8} and 33 states allow its use, including nearby Iowa.⁹
- It mandates that patients must receive counseling from a physician and then return to the *same* physician to be observed while taking mifepristone, the first pill. In effect, this act requires the same physician to examine the patient, obtain consent, and schedule a subsequent appointment after the separately mandated 24-hour waiting period when that same physician will be available again, so they can watch the patient take the mifepristone pill. Thus, Act 217 mandates patient visits on multiple days for what only medically requires one clinical visit or one telemedicine consultation.¹⁰ This same burden is not mandated for surgical abortions.

These mandates are not consistent with best practices determined by major medical organizations such as the American College of Obstetricians and Gynecologists,¹¹ the premier professional organization in the U.S. for obstetrician-gynecologists.

Act 217 greatly compounds preexisting restrictions on abortion care access in Wisconsin. Table 1 presents some of the abortion-related restrictions enacted into state law since 1977. Along with 28 other states, Wisconsin is now considered “hostile” to abortion health care.¹² This hostility includes the closure of several reproductive healthcare facilities in the last decade, as well as state-mandated 24-hour waiting period, ultrasound viewing, and medically inaccurate counseling. Wisconsin Medicaid and insurance for state workers denies coverage for both surgical and medication abortion services in almost all cases, even though it does

pay a large number of other reproductive health services, including prenatal and birthing care. Therefore, most people must pay for abortion care out of pocket—an expense that many lower-income patients cannot afford.¹³ Wisconsin’s medically unnecessary requirements are especially onerous for rural and low-income residents, including Black and Indigenous people, and other people of color.¹⁴

Table 1. Overview of Wisconsin Abortion Restrictions Implemented from 1997-2018¹⁵⁻¹⁸

Restriction	Year	Law
Public funding is available for abortion only in cases of life endangerment, rape, incest or when the procedure is necessary to prevent long-lasting damage to the patient's physical health.	1977	Wis. Stat. Ann. § 20.927
The parent of a minor must consent before an abortion is provided; health professionals are allowed to waive parental involvement in limited circumstances.	1991	Wis. Stat. Ann. § 48.375
A patient must receive state-directed counseling that includes information designed to discourage the patient from having an abortion, and then wait 24 hours before the procedure is provided. Counseling must be provided in person and must take place before the waiting period begins, thereby necessitating two trips to the facility.	1995	Wis. Stat. Ann. § 253.10
Health insurance plans offered in the state’s health exchange under the Affordable Care Act can only cover abortion in cases of life endangerment or severely compromised physical health, or in cases of rape or incest.	2012	Act 217: Wis. Stat. Ann. § 632.8985
Only physicians are allowed to provide abortions.	2012	Act 217: Wis. Stat. Ann. § 253.10
The same physician who conducts the consent and physical exam must prescribe and administer medication abortion in person, also preventing the use of telemedicine for medication abortion provision.	2012	Act 217: Wis. Stat. Ann. § 253.105
A patient must undergo an ultrasound before obtaining an abortion; the provider must show and describe the image to the patient.	2013	Wis. Stat. Ann. § 253.10 (3) (c) 5
An abortion may be performed at 20 or more weeks postfertilization (22 weeks after the last menstrual period) only in cases of life endangerment or severely compromised health.	2015	Wis. Stat. Ann. § 253.107
Abortion is covered in insurance policies for public employees only in cases of life endangerment or severely compromised physical health, or in cases of rape or incest.	2018	Wis. Stat. Ann. § 40.56

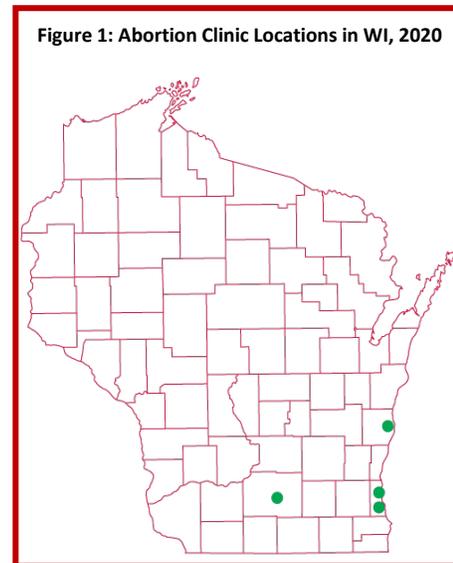
The Need for Wisconsin-Specific Data

Research conducted in other states has shown that restrictive abortion laws have negative effects on both patients and providers.¹⁹ For example, reproductive healthcare providers in North Carolina reported that targeted restrictions on abortion care negatively affected clinical care and eroded trust and rapport between patients and providers.²⁰ Researchers also found that implementation of abortion restrictions in Ohio led to patients presenting for abortion care at later gestations; these restrictions also created significant barriers to reproductive healthcare access, particularly in rural communities.²¹ Researchers from the University of Wisconsin-Madison documented that restrictions contributed to the closure of

40% of Wisconsin's state's abortion facilities between 2009 and 2017.¹⁶ Another University of Wisconsin-Madison study showed that, in counties where the distance from an abortion clinics increased after these closures, the birthrate increased.¹³

However, no research has specifically documented the impact of Act 217 on patients and providers in Wisconsin. This research gap is notable given that Wisconsin has one of the most restrictive environments in the U.S. for medication abortion care. An interdisciplinary research team from the Collaborative for Reproductive Equity at University of Wisconsin-Madison set out to address this gap. The

team was led by Drs. Jenny Higgins and Laura Jacques, with significant research assistance from Taryn Valley, Barbara Alvarez, Corinne Hale, and Emma Carpenter.



Talking to Wisconsin Healthcare Professionals Who Provide Abortion and Other Reproductive Healthcare Services

The research team interviewed 22 Wisconsin healthcare professionals who either currently provide abortion care services or have provided them in recent years. Eighteen of these interviewees were physicians and four were non-physician providers involved in patient care (e.g., nurses and patient care specialists). Investigators asked interviewees about their experience providing medication abortion care services and how, if at all, current Wisconsin policies affect their work and their patients. Investigators also included a question about the COVID-19 pandemic and its effects on abortion care provision and access.

An independent transcription service transcribed the interviews word-for-word. Investigators then used well-established qualitative research methods²² to analyze the interviews for themes. They developed a coding report and began applying those codes to blocks of text, meeting regularly to establish consensus. Investigators then worked with coding reports to assess providers' most commonly reported issues, as well as the magnitude of those concepts.

Research Findings

Overall, **investigators found overwhelming evidence that reproductive healthcare professionals believe current medication abortion care restrictions in Wisconsin undermine both patient care and provider capacity.** While interviewees underscored how all restrictions work synergistically to hinder access to abortion services, they emphasized that Act 217's same-physician restriction and ban on telemedicine, as well as the

24-hour waiting period mandated by a 1995 law, are especially harmful to patients. They described these restrictions as being most deleterious for socially disadvantaged Wisconsin residents, including low-income people, Black women and other women of color, rural residents, people under the age of 18, and those experiencing intimate partner violence or abuse.

Effects of the Same-Physician Restriction

Consistently, providers indicated that the Act 217 **same-physician requirement was the regulation that most negatively affects medication abortion care provision:**

Interviewer: If you had to pick one regulation that's most impacted your provision of medication abortion, which one would be?

Interviewee: Well, it would be the same doctor, same pill law. That's the biggest one.

Another physician similarly stated:

[The abortion regulation that most affects provision of medication abortion care is] probably the same-physician consent. It's not something that they used to have much of a problem with at the clinic where I work. But more recently, I've seen several women who have come in for a consent for an abortion and then ended up deciding on a medication abortion. But the provider who was there to sign consents with them wasn't going to be there for another few weeks and that would put them beyond the gestational-age limit for medication abortion.

Providers especially highlighted how the same-physician restriction compounds the burden of the 24-hour waiting period requirement. Although interviewees described how the same-physician restriction is by itself unnecessary and burdensome, in conjunction with the 24-hour law the restriction is dramatically more burdensome. Access would be much less affected if physicians could help patients take the first medication on the same day they consented and counseled the patients. Together, the same-physician and 24-hour waiting period requirements exact unnecessary burdens on patients and physicians.

Physicians consistently described how these two regulations make it difficult for patients to get timely and continuous care, especially for those traveling from a long distance. Such distances are necessitated by the existence of only four abortion healthcare clinics in three parts of the state: Madison, Milwaukee, and Sheboygan (Figure 1). This obstacle is compounded by the fact that the overwhelming majority of physicians have full-time practices elsewhere and can only provide abortion services at clinics one day or one half-day per week. A commonly expressed sentiment among interviewees is captured well by the following physician:

There's a requirement for the physician in front of whom the patient has signed a consent for the pill...that same physician has to administer the pill personally and be in the room when the patient swallows it. If the doctor can't get back to the clinic until next week, the patient has to wait a week, come back, and take the pill in front of the doctor who signed the consent with her the week before. As you can imagine, this presents a tremendous...not just inconvenience, but a barrier for women who drive three and four hours to come and take a pill or to sign a consent and then come back and take a pill, and then come back a third time for a follow up.

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So if they're driving from Marinette [a city located in the Northeast corner of Wisconsin], they have to make a three-and-a-half, almost four-hour drive to have their counseling, sign the consent, drive home, then come back, take the pill, and drive home again—now we're talking up to 16 hours of driving.

This sentiment is similarly captured by the following quote from another interviewee:

The whole same-provider, two-day thing with medication abortion, especially in the more rural clinics, was extremely tough, because it was really hard to get a provider who was available to do back to back, let alone patients who were already struggling to get one day off of work or anything else, to have to do all this two-day business, and then meet the window of time when they changed the time frame.

Another physician went further, explaining how patients affected by structural or logistical barriers experience significant burdens to accessing medication abortion:

The need to have the in-person visit for counseling, the in-person visit for the administration...that's a really major restriction, especially for women in rural counties. There are many restrictions that make [medication abortion care] prohibitive for everyone, but it's much worse for women who have to drive two, three, even four or five hours to a clinic appointment, who need to take time off work, need to find childcare, need to explain to family and friends why they need to do these things...It really is a barrier to accessing a same form of abortion that could be more accessible to women if there weren't legislative barriers.

A final example of this theme is as follows:

[The abortion regulation that most affects provision of medication abortion care is] the two-day process. The fact is that women come in having heavily weighed their options, and have often significantly researched all the options. There are definitely states providing same-day services safely. And if I were to be able to go and see women and provide on the same day, the difficulties of the logistics of trying to provide care would be dramatically reduced—without any increased adverse outcomes.

Such delays can sometimes mean that someone becomes too far along in her pregnancy to receive medication abortion services:

If the patient who lives far away can't come back for, let's say two weeks, she's two weeks farther along. [...] The delay in being able to terminate the pregnancy under our current system is yet another factor that makes it rougher and less successful for the patient.

Delays could also diminish patients' choices, forcing them to select a surgical abortion when they originally had wanted a medication abortion:

I certainly saw many times that women were obligated to having a surgical procedure when they really had hoped to have a medical procedure because there wouldn't be a provider there twice before they became too far in gestational age to qualify for the medication abortion process many times.

Some **providers expressed frustration that current Wisconsin restrictions are not evidence-based** and fail to follow protocols used in some other states.

"There are certainly good ways to counsel people virtually by video or by phone. There are many other states in which that's done...plus many other states that don't require a waiting period because—again—women are capable of making their own good, informed decisions."

[The abortion regulations that most affect medication abortion care are] the requiring of in-person, face-to-face counseling and that the medication must be administered by a medical doctor. Those two regulations are not based in good science and not based in offering the best patient care. [...] There are certainly good ways to counsel people virtually, either by video or by phone. There are many other states in which that's done...plus many other states that don't require a waiting period because—again—women are capable of making their own good, informed decisions.

As the previous quotation suggests, **providers also described the same-physician restriction and 24-hour waiting period as purposely obstructionist as well as condescending to women**, who have already considered the options and carefully arrived at their decision. As one provider stated:

When I give my patients mifepristone, I have to sit in the room and treat them like a fourth grader and make sure they swallow the pill. [...] Because of the nature of various laws, the way we do it here [in Wisconsin] is designed to make it tough on people.

And another:

When I think about providing abortion services in Wisconsin, some of the restrictions on providing that care didn't seem to be about providing the best medical care, but were obvious barriers to women and impositions from the legislature into the patient-doctor relationship. [...]

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But that's a patriarchal attitude. It just strikes me as offensive to assume that someone has put no thought into it before talking to a doctor, or that she doesn't have the decision-making capacity to decide for her own health and family and life. Mandating that those counseling sessions happen face-to-face is not the standard of care for many other medical situations.

Providers highlighted that Wisconsin regulations hold abortion to a uniquely stringent standard compared to other healthcare procedures and practices.

I see [non-abortion] patients in my current role as a hospitalist, so 100% of my patients were counseled by a different physician and then meet me on the day of the procedure. So it's very hard to argue that the same provider is needed for abortion care; it's certainly not the standard in any other aspect of medical care.

And:

There are no other health issues that the state prescribes how long a woman must think about a certain topic.

And finally:

If I saw a patient for birth control in the office, and they wanted the prescription filled from their primary physician, somebody else would fill it. Someone who understands the issues already provided the patient with the counseling. So another provider should be able to administer medication abortion, too.

Providers also pointed out that Act 217 treats medication abortion differently than surgical abortion in a way that highlights its exceptionally stringent regulation:

It's really inconsistent to think that, to use the pill, the same doctor has to be the same person doing it, whereas if a woman decides to have the surgical, any of the other doctors can do that procedure. So what, where's the consistency in that? So I would say that the, however it's termed, the same-doctor, same-pill, same-patient law is the single biggest problem with access.

Providers indicated that current Wisconsin abortion regulations hold no health benefits for patients, and in fact can only undermine their ability to get medication abortion services at earlier stages of pregnancy, if at all.

Restrictions decrease choice, right? People have to make decisions a lot of times that aren't based on what they actually think is best for them but what's available for them. Maybe a patient wants a medication abortion and they learn that the next time that I'm going to be back in the clinic that they'd be over 11 weeks. So then they decide to change to a surgical abortion, which is not what they truly felt most comfortable with and not what they truly wanted. They do it because a restriction is forcing them to, even though there is no evidence-based reason why they should have to do that.

[..] Then they have to think about how to have someone be there with them because they want to get sedation. They need a driver. So then you're getting into 11, 13, 15 weeks. We know that abortion is incredibly safe, but we also know that risks do increase slightly with greater gestational age.

Providers repeatedly underscored the particular cost of restrictions on Wisconsin's low-income residents, as captured by the following interviewee:

The most susceptible people are the people that we are burdening even more with all of these additional restrictions. And then, we delay them even more, which means that the cost is going to go up even more. [...] So I think restrictions directly decrease choice, decrease access, and directly affect patients of lower socioeconomic status, lower access, lower support.

Finally, interviewees underscored the costs of these regulations to providers' ability to schedule patients, as well as providers' capacity and wellbeing—a phenomenon amplified by COVID-19:

The same-doctor rule means I can't afford to be sick or not show up. I have to move heaven and earth to get there if my daycare's closed or my kids are sick.

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My current schedule is that I work at the clinic every Friday. So if a patient sees me on Friday and they're supposed to come back the following Friday, if I have a cold or any COVID symptoms, that person would then have to start the whole process over with a new physician. For a lot of women, this delay would put them outside of the window for when they could get medication abortions at all.

For us to do a medication abortion amidst COVID is really terrible. I'm a mother of young children whose daycare might suddenly get cancelled, or I might get sick myself. I face the pressure of, "Gosh, how bad is this cold?" I know I shouldn't go to work if I have a cold. But if I don't go to work, that means the women I saw a week ago, the ones who are counting on me as being able to provide their medication abortion, can't have it. It's a terrible place to be in as a provider.

Providers highlighted not only emotional costs but also logistical costs:

Providers have to change their work schedule to accommodate the face-to-face appointments, driving two hours to get to your work location, then coming home in the evening and making yourself available at another time in a timely fashion so patients can have follow-up care directly with you...or asking patients to drive an additional two hours beyond the clinic where they were originally seen. [...] The distance traveled by all parties in this situation can be staggering.

Another provider expressed a similar sentiment:

Interviewer: If you had to identify one regulation, particularly around medication abortion, that you came across in your time working in abortion provision, what would you say impacted practice the most?

"The same-provider rule just changed everything. It changed who we had available, our availability, our scheduling. So providers were having the try to shift their other jobs to try to accommodate. And we lost some providers over it, which isn't ideal in a state where you don't have that many providers to begin with."

Interviewee: The same-provider issue, I would say. Before that law, we had somebody who did all the medication abortion care, and so it was great that he was available to do that. And then the same-provider rule just changed everything. It changed who we had available, our availability, our scheduling. So providers were having the try to shift their other jobs to try to accommodate. And we lost some providers over it, which isn't ideal in a state where you don't have that many providers to begin with.

Effects of the Telemedicine Ban

For Wisconsin residents, the average distance to the nearest abortion clinic is 55 miles—although many Wisconsin residents have to travel 100 miles or more.¹⁴ Seventy percent of the state’s population reside in counties without a clinic, necessitating some form of travel if they wish to obtain an abortion.¹⁵ The impact of this distance is felt most by women of disadvantaged socioeconomic status, especially those in rural areas.¹⁴

One way to mitigate the negative impact of distance for patients is the use of telemedicine for medication abortion. Research has documented the safety and efficacy of telemedicine for medication abortion services,^{3,6,7,9,23} and Wisconsin is one of only 17 states that prohibits its use. **Providers in our study consistently argued that telemedicine services should be legal and accessible, particularly for Wisconsin residents with difficulty accessing in-person care (e.g., rural, low-income individuals, or people experiencing intimate partner violence).** As one provider stated:

They are already often times in situations where there are financial strains and barriers, there’s all kinds of domestic violence, and there are cases where people are really just on their own without resources. So the more times they have to take off work if there is work, or get in a car if there is a car, and come to the clinic, that really limits them. [...] And in particular, providing really quality medication abortion services by physicians and other trained providers via a telehealth platform would be something that would be a real positive force in public and population health in Wisconsin.

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Another provider made a similar argument:

Well, [the people who have the poorest access] are still basically socioeconomically disadvantaged people and those who don't have the freedom to take off from their job whenever they want, for one, that don't have the transportation to come twice. There’s really no good reason why most of the medication abortions couldn't really be provided over the telephone.

In addition to geographic barriers, the COVID-19 pandemic has further complicated in-person delivery of medication abortion in Wisconsin. Due to a desire to minimize face-to-face contact whenever possible in order to limit the spread of the virus, more healthcare systems have relied on telemedicine to offer an enormous range of healthcare services. In this context, **providers underscored that Wisconsin’s telemedicine ban has especially negative effects on patients in a time of COVID-19.**

In my other clinic, we are bending over backwards to keep people home and have them do video visits for anything that we can see on a video, like toe issues, skin issues, mental health, birth control discussions. But with abortion care, you have to see a patient in-person twice.

Another provider emphasized the same idea:

There's a possibility that patients are waiting to come in for care at all because they worry of contracting the virus in a medical facility, even though medical facilities don't really service patients who have known to be infected. But COVID may scare someone away from getting any medical care during their pregnancy one way or the other. So that's worrisome.

And the in-person consent is totally unnecessary and makes things even more frustrating in a pandemic when people are scared of getting out when you could do all of that telehealth. And you could be providing medication abortion by telehealth in general.

Conclusion

In this study, healthcare providers described substantial obstacles facing Wisconsin residents who seek medication abortion care. Investigators found that especially when contextualized in the existing thicket of state restrictions on abortion, Act 217's regulations have resulted in notable reduction of medication abortion care access. The prohibition of telemedicine abortion, even while U.S. healthcare is experiencing a widespread scaling-up of other types of telemedicine, adds barriers to patients seeking medication abortion care, especially in light of COVID-19. Provider interviewees clearly and repeatedly documented how the same-physician rule of Act 217 turns a 24-hour waiting period into weeks or even months. For many, these obstacles make it functionally impossible to obtain medication abortion care, often patients' chosen method. They thus need to start the process anew, potentially receiving a surgical abortion later in the pregnancy because of these legal hurdles. **The total impact of Act 217, with the legal barriers that existed before it, is greater than the sum of its restrictions.**

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