Bill as Introduced

HB 629-FN - AS INTRODUCED

2015 SESSION

15-0174
01/09

HOUSE BILL ***629-FN***

AN ACT relative to induced termination of pregnancy statistics.

SPONSORS: Rep. Souza, Hills 43; Rep. Notter, Hills 21; Rep. Kappler, Rock 3; Rep. Berube, Straf 18; Rep. Wuelper, Straf 3; Rep. Gould, Hills 7; Rep. Prudhomme-O'Brien, Rock 6; Rep. Cordelli, Carr 4; Rep. Leeman, Straf 23; Sen. Cataldo, Dist 6; Sen. Daniels, Dist 11

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill requires the department of health and human services to keep an annual statistical report of each induced termination of pregnancy performed and submit such report to the general court. The report shall also be available to the public.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

15-0174
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Fifteen

AN ACT relative to induced termination of pregnancy statistics.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Annual Report Required. Amend RSA 126-A by inserting after section 4-h the following new section:

126-A:4-i Induced Termination of Pregnancy; Annual Report.

I. In this section:

(a) "Abortion clinic" means a facility, other than an accredited hospital, in which 5 or more first trimester abortions in any month or any second or third trimester abortions are performed.

(b) "Aggregate summary" means compilation of the information received by the department of health and human services on induced terminations of pregnancy.

(c) " Department" means the department of health and human services.

(d) " Division" means the division of vital records administration, department of state.

(e) "Facility" or "medical facility" means any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

(f) "Health care provider" means any individual licensed to provide health care under RSA 326-B:11 or RSA 329 and who provides induced terminations of pregnancy.

(g) "Identification number for health care provider of facility" means a confidential identifier for a health care provider or a facility including the location of the health care provider or the facility by city, town, or county.

(h) "Induced termination of pregnancy" means the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant and which does not result in a live birth. This definition excludes management of prolonged retention of products of conception following fetal death.

(i) "Non-surgical induction" means the administration of a medication or medications to induce a termination of pregnancy.

(j) "Patient confidential identification code or number" means a confidential identifier for a patient including primary residence by state and city, town, or county.

(k) "Procedure" means the process by which an induced termination of pregnancy occurs.

II.(a) The division shall collect non-identifying confidential data on induced termination of

pregnancy occurring within the state of New Hampshire using the New Hampshire Vital Record Information Network (NHVTIN) electronic system or any modified or replacement electronic system. Each health care provider or facility shall use an electronic form for such purpose. The electronic form shall be made available by the department to each health care provider or facility. The form shall be the most current form used for such purpose by the federal Centers for Disease Control and Prevention or on a form which is substantially similar to such form. The department shall assign a confidential number to each health care provider and facility required to submit the electronic form under this section. The confidential number, or any other personally identifiable information, obtained under this paragraph shall be exempt from disclosure under RSA 91-A.

(b) The electronic form shall be completed by the health care provider or the facility and securely transmitted to the division on or before the 15th day of each month for all induced terminations of pregnancy occurring within the previous month. If no procedures were performed, it shall be indicated as "none" on the electronic form.

(c) The department shall have sole responsibility for the analysis of the data and the preparation and distribution of the aggregate summary.

(d) The department shall publish an annual report, commencing on November 1, 2016, to be posted on the department's Internet website, based on an aggregate summary of the information obtained pursuant to this section.

III. The electronic form provided by the department shall include the following data:

(a) The confidential identification number for the health care provider or facility.

(b) The patient's confidential identification code or number.

(c) The patient's marital status.

(d) The patient's use and, if applicable, type of contraception.

(e) The patient's age.

(f) The gestational age of the fetus.

(g) The patient's medical insurance status.

(h) The highest level of education obtained by patient.

(i) The town, city, or county of the address of the patient.

(j) Date of termination.

(k) Method of termination.

IV.(a) Notwithstanding RSA 126:28 and except as otherwise provided in this section, information obtained by the department under this section shall be used only for statistical purposes and such information shall not be released in a manner which would lead to or permit the identification of the person for whom the procedure was performed. Any releases of the information obtained shall not disclose or permit the identification of any person filing a report, the facility at which the procedure was performed, or the identity of any person licensed to practice medicine and surgery who submits a report to the department under this section, except as follows:

(1) Information from reports provided, including information identifying such persons and facilities, may be disclosed to the state board of medicine upon request of the board for disciplinary action conducted by the board and may be disclosed to the attorney general upon a showing that a reasonable cause exists to believe that a violation of this section has occurred. Any information disclosed to the state board of medicine or the attorney general pursuant to this section shall be used solely for the purposes of a disciplinary action or criminal proceeding.

(2) Information from reports shall be provided to the federal Centers for Disease Control and Prevention for the purposes of national statistical summaries provided these summaries do not lead to any other disclosures as stated in this section.

(b) A violation of this section is a class B misdemeanor.

V. If any provision of this section, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this section which can be given effect without the invalid provision or application, and to that end the provisions of this section are severable.

2 Effective Date. This act shall take effect January 1, 2016.

HB 629-FN - AS AMENDED BY THE HOUSE

6Jan2016... 2551h

2015 SESSION

15-0174
01/09

HOUSE BILL ***629-FN***

AN ACT relative to induced termination of pregnancy statistics.

SPONSORS: Rep. Souza, Hills 43; Rep. Notter, Hills 21; Rep. Kappler, Rock 3; Rep. Berube, Straf 18; Rep. Wuelper, Straf 3; Rep. Gould, Hills 7; Rep. Prudhomme-O'Brien, Rock 6; Rep. Cordelli, Carr 4; Rep. Leeman, Straf 23; Sen. Cataldo, Dist 6; Sen. Daniels, Dist 11

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill requires the department of health and human services to publish an annual report consisting of an aggregate statistical summary of all induced terminations of pregnancy performed in New Hampshire. This report shall be available to the public. Data submitted by providers shall be for statistical purposes only and not public records.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Fifteen

AN ACT relative to induced termination of pregnancy statistics.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Annual Report Required. Amend RSA 126-A by inserting after section 4-h the following new section:

126-A:4-i Induced Termination of Pregnancy; Annual Report.

I. In this section:

(a) "Aggregate summary" means compilation of the information received by the department of health and human services on induced terminations of pregnancy.

(b) "Department" means the department of health and human services.

(c) "Division" means the division of vital records administration, department of state.

(d) "Facility" or "medical facility" means any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center, or other institution or location wherein medical care is provided to any person.

(e) "Health care provider" means any individual licensed to provide health care under RSA 326-B:18 or RSA 329 and who provides induced terminations of pregnancy.

(f) "Identification number for health care provider of facility" means a confidential identifier for a health care provider or a facility including the location of the health care provider or the facility by city, town, or county.

(g) "Induced termination of pregnancy" means an intervention performed by a licensed clinician, including a physician, nurse, midwife, nurse practitioner, or physician assistant, that is intended to terminate an ongoing pregnancy.

(h) "Patient confidential identification code or number" means a confidential identifier for a patient including primary residence by state and city, town, or county.

(i) "Procedure" means the process by which an induced termination of pregnancy occurs.

II.(a) The division shall collect non-identifying confidential data on induced termination of pregnancy occurring within the state of New Hampshire using the New Hampshire Vital Record Information Network (NHVRIN) electronic system or any modified or replacement electronic system under the jurisdiction of the division. The division shall bear all responsibility for maintaining the confidentiality of these records. These data shall be stored using only the confidential number of the health care provider assigned by the department to the provider prior to the submission of the form. Provider names or other identifying data shall not be stored in the division or department

data systems. These data shall only be released to the department as authorized by this section. Each health care provider or facility shall use an electronic form for such purpose. The electronic form shall be made available by the department to each health care provider or facility. The form shall only require disclosure of information required under this section. The department shall assign a confidential number to each health care provider and facility required to submit the electronic form under this section. The confidential number, or any other personally identifiable information, obtained under this paragraph shall be for statistical purposes only and therefore be exempt from disclosure under RSA 91-A.

(b) The electronic form shall be completed by the health care provider or the facility and securely transmitted to the division on or before the 15th day of each month for all induced terminations of pregnancy occurring within the previous month. The electronic form shall only be submitted if induced terminations of pregnancy were performed in the preceding month.

(c) The department shall have sole responsibility for the analysis of the data and the preparation and distribution of the aggregate summary.

(d) The department shall publish an annual report, commencing on November 1, 2017, to be posted on the department's Internet website, based on an aggregate summary of the information obtained pursuant to this section. No data may be released by the department that would have the capacity to personally identify either the health care provider who performed the induced termination of pregnancy or the patient on whom it was performed.

III. The electronic form provided by the department shall include the following data:

(a) The confidential identification number for the health care provider or facility.

(b) The patient's confidential identification code or number.

(c) The patient's use and, if applicable, type of contraception.

(d) The patient's age.

(e) The estimated gestational age of the fetus as determined by the health care provider using as a reference the 2014 American College of Obstetricians and Gynecologists guidelines or any subsequent editions thereto.

(f) The county or municipality if the population of the municipality exceeds 20,000 based on the United States Census Bureau of the address of the patient. If the patient is a resident of another state, then indicated as out-of-state.

(g) Date of termination by month and year.

(h) Method of termination as follows:

(1) Curettage;

(2) Intrauterine installation;

(3) Medical (nonsurgical); or

(4) Other as specified by the health care provider.

IV. The department's annual report shall provide aggregate data using the following fields:

(a) The county or municipality if the population of the municipality exceeds 20,000 based on the United States Census Bureau of the address of the patient. If the patient is a resident of another state, then indicated as out-of-state.

(b) The patient's use and, if applicable, type of contraception.

(c) Patient age listed in ranges as determined by the department using Centers for Disease Control and Prevention (CDC) guidelines.

(d) Gestational age of the fetus listed in ranges as determined by the department using CDC guidelines.

(e) Method of termination as follows:

(1) Curettage;

(2) Intrauterine installation;

(3) Medical (nonsurgical); or

(4) Other as specified by the health care provider.

V.(a) Notwithstanding RSA 126:28 and except as otherwise provided in this section, information obtained by the department under this section shall be used only for statistical purposes and such information shall not be released in any manner other than that outlined in this section for preparation of the reports. Such release shall not occur in any manner which would lead to or permit the identification of the person on whom the procedure was performed. Any releases of the information obtained shall not disclose or permit the identification of any person filing a report, the facility at which the procedure was performed, or the identity of any health care provider as defined in RSA 126-A:4-i, I(d) who submits a report to the division under this section. The information obtained by the department in RSA 126-A:4-i, III(a), regarding the confidential identification number for the health care provider or facility, and RSA 126-A:4-i, III(b), regarding the patient's confidential identification code or number, shall only be used for internal auditing and quality assurance purposes by the department.

(b) Excluding any aggregate summary as defined in RSA 126-A:4-i, I(a), the department and division shall purge all data collected and obtained under this section after 3 years.

VI. If any provision of this section, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this section which can be given effect without the invalid provision or application, and to that end the provisions of this section are severable.

2 Effective Date. This act shall take effect January 1, 2017.

LBAO
15-0174
Revised 02/25/15

HB 629-FN FISCAL NOTE

AN ACT relative to induced termination of pregnancy statistics.

FISCAL IMPACT:

The Department of Health and Human Services, Department of Justice, New Hampshire Association of Counties, and Judicial Branch state this bill, **as introduced,** will increase state and county expenditures by an indeterminable amount in FY 2016 and each year thereafter. There will be no fiscal impact on local expenditures, or state, county, and local revenue.

METHODOLOGY:

The Department of Health and Human Services (DHHS) states this bill requires the Department to; collect certain non-identifying confidential statistical data relative to induced termination of pregnancies; report such data annually to the Federal Center for Disease Control and Prevention; and publish an annual report based on an aggregate summary of the data to the Department's website. The bill requires health care providers to submit data monthly, and specifies a violation of the provisions of the proposed legislation shall be a class B misdemeanor. DHHS states the establishment of policies and procedures for the collection and reporting of the required data followed by the implementation and execution of those policies and procedures will increase state expenditures by approximately $3,369 in FY 2016, $1,527 in FY 2017 through FY 2018, and by $1,618 in FY 2019.

The Department of Justice (DOJ) and the New Hampshire Association of Counties state the proposed legislation establishes a class B misdemeanor. Neither the DOJ nor the Association has sufficient information to estimate the additional number of class B misdemeanors that may arise as a result of the bill's passage. The Association notes to the extent the proposed legislation results in class B misdemeanors requiring prosecution, county expenditures will increase. The DOJ notes to the extent these prosecutions are appealed to the Supreme Court state expenditures will increase.

The DOJ states a violation of the bill may also result in a complaint to and potential disciplinary action from the State Board of Medicine. The DOJ notes to the extent any disciplinary actions brought by the Board of Medicine require the services of their Administrative Prosecutions Unit, state expenditures will increase.

The Judicial Branch states they have no information on which to estimate how many

additional class B misdemeanor prosecutions may result from the proposed legislation. However, the Branch estimates the average cost of processing a class B misdemeanor to be $48.47 in FY 2016 and $50.63 in FY 2017. Accordingly, the Branch states if passage of the proposed legislation resulted in an additional 207 class B misdemeanors, state expenditures would increase by over $10,000. The Branch notes this does not account for the costs of any appeals which could further increase state expenditures by an indeterminable amount.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Andy Sanborn, Chair
Sen Molly Kelly, Vice Chair
Sen Kevin Avard, Member
Sen Sharon Carson, Member
Sen Martha Fuller Clark, Member

Date: March 3, 2016

HEARINGS

Tuesday	03/08/2016
(Day)	(Date)

Health and Human Services	LOB 101	1:00 p.m.
(Name of Committee)	(Place)	(Time)

EXECUTIVE SESSION MAY FOLLOW

1:00 p.m.	**SB 431**	relative to the comprehensive health care information system.
1:20 p.m.	**SB 439**	establishing a commission to study the shortage of nurses for pediatric home health services.
1:50 p.m.	**HB 629-FN**	relative to induced termination of pregnancy statistics.
2:20 p.m.	**HB 1193**	relative to the wellness and primary prevention council.

Sponsors:

SB 431			
Sen. Stiles	Sen. Fuller Clark	Rep. M. Smith	Rep. LeBrun
Rep. Bates			
SB 439			
Sen. Woodburn	Sen. Kelly	Sen. Fuller Clark	Sen. Sanborn
HB 629-FN			
Rep. Souza	Rep. Notter	Rep. Kappler	Rep. Berube
Rep. Wuelper	Rep. Gould	Rep. Prudhomme-O'Brien	Sen. Cataldo
Rep. Cordelli	Sen. Daniels	Rep. Leeman	
HB 1193			
Rep. B. French	Rep. Fothergill	Rep. Wallner	Sen. Fuller Clark
Sen. Watters	Sen. Carson		

Kelly Flathers 271-3091

Andy Sanborn
Chairman

Senate Health and Human Services Committee

Kelly Flathers 271-3091

HB 629-FN, relative to induced termination of pregnancy statistics.

Hearing Date: March 8, 2016

Time Opened: 3:04 p.m. **Time Closed:** 4:01 p.m.

Members of the Committee Present: Senators Sanborn, Kelly, Avard and Carson

Members of the Committee Absent: Senator Fuller Clark

Bill Analysis: This bill requires the department of health and human services to publish an annual report consisting of an aggregate statistical summary of all induced terminations of pregnancy performed in New Hampshire. This report shall be available to the public. Data submitted by providers shall be for statistical purposes only and not public records.

Sponsors:

Rep. Souza	Rep. Notter	Rep. Kappler
Rep. Berube	Rep. Wuelper	Rep. Gould
Rep. Prudhomme-O'Brien	Sen. Cataldo	Rep. Cordelli
Sen. Daniels	Rep. Leeman	

Who supports the bill: Tricia Tilley - NH DHHS; John Williams - NH DHHS; Sarah Koski - Cornerstone; Jennifer Martin - Roman Catholic Diocese of Manchester; Sen. Daniels - District 11

Who opposes the bill: Devan Chaffee - ACLU NH; Rep. Kurk - Hillsborough 2

Who is neutral on the bill: Stephen Wurtz - Division of Vital Records

Summary of testimony presented in support:
Rep. Kurt Wuelper - Strafford 3 (Co-Sponsor): This topic has come to the House Health and Human Services committee a number of times and we have now reached a place where everyone can agree. The bill passed the committee with a unanimous vote onto the consent calendar without objection. We are attempting to gather information on abortion in the state of NH to augment the information we have for public health reasons. Everyone agrees that there are too many abortions and that we'd like to see that number reduced. However, we have no real way to see the scope of abortion in our state, such as where, when, and on whom they are performed. All of this information is important in terms of targeting public health resources to help minimize this

problematic situation. This bill gathers no more information than is submitted by 47 other states to the Center for Disease Control and uses a format similar to theirs. We have taken great care to protect the privacy of any woman who gets an abortion. When the Department creates statistical reports, the data would be aggregated on a large enough level that it would not be possible to identify any individual.

Senator Kelly: Could you clarify what the intent of this bill is?

Rep. Wuelper: The intent is to gather numbers- factual information surrounding abortion in our state. We have no way of knowing what is actually happening and cannot target any resources to correcting the problem.

Senator Kelly: Why would we need to target resources?

Rep. Wuelper: The general consensus is that we should minimize the number of abortions. The primary ways we do that are through public health resources and education.

Senator Kelly: Can you define general consensus?

Rep. Wuelper: Having been involved in these types of issues for a number of years, I've never heard anyone say that we shouldn't try to minimize the number of abortions.

John Williams - NH DHHS: A lot of time, energy, and work has gone into putting the interest of public health first in this bill. We are not looking at it from any political standpoint, only what would help NH citizens. This started as legislation in 2013 under HB 1550. There were too many problems with the bill having unintended consequences, including concerns regarding potential breaches in personally identifiable information. In 2015 the bill came around again, building on earlier successes and progressing throughout the summer and fall. There are significant changes in this version. We worked with the House committee to ensure that it met the goals of the public health needs of NH citizens while protecting the privacy of those individuals in the data. We looked at our neighboring states and drilled it down to the types of forms we would use. We gave up a lot information that would be useful from a public health standpoint in order to strike a balance. The fiscal note associated with this bill was attached in February 2015. The bill has been markedly changed since then. Our agency anticipates the need of about 0.04 of a full time employee to put together the report generated from these data in the first year. In following years, we would need about 0.02 of a full time employee. We wanted to build this into something that is already in existence, which is why we're bringing it in through vital records and statistics. They have never experienced any sort of data breach before. This first part of this legislation was worked down to very concrete definitions with an emphasis on confidentiality. Part two identifies the role and function of NH and the Division of Vital Records. Part three identifies exactly which data we would be collecting. CDC has about twice the list that you see here. This came as a significant compromise by the Department because we wanted to get additional information that would be helpful from a public health perspective but we had to honor the will of the committee to avoid

identifiable information. We agree that clarifying that the identifying number is self-provided in the definition would be useful. In addition to these numbers, we would collect the gestational age of the fetus (as defined by one definitive clinical authority), the county or municipality, when the termination took place, and the method of termination. This is not a lot of information. There is value in this information, but it is only half of what we were originally looking for. Part four talks about the report. It must be aggregate information- no personally identifying information will be released as a result of this report. The last section of the bill further protects patient and provider privacy. The data is not discoverable under 91:A and HIPAA applies to this as well. We cannot guard against every single bad actor, but this minimizes risk. We did not request this bill but we do support it and will find it useful.

Tricia Tilley - NH DHHS: There is a public health interest in this issue. In NH we have among the lowest teen birth rates in the country. Our unintended pregnancy rates among all women are lower than the national average. However, we don't have specific information around pregnancy, while 47 other states do. This is surveillance, a public health activity. We would use this information to target the limited resources we have on reproductive health. This would better inform our efforts on implementing pregnancy prevention programs to get to a point where we have fewer unintended pregnancies that might lead to abortion. The piece in the bill on methods is important for us to know for quality assurance and safety. This information would be useful to patients, families, and providers.

Senator Kelly: I am still concerned about the intent of this legislation. Trisha, you are trying to find out how many pregnancies there are in the state. Rep. Wuelper said the purpose was to minimize abortions. What are you looking for?

John Williams: This is Senator Souza's bill. The commentary by Rep. Wuelper is not our goal for the purposes of this bill. If you were to talk to the prime sponsor and other people who collaborated, you may have a different idea of what the intent was.

Senator Kelly: You said you limited the number of elements you were looking for, compared to the Centers for Disease Control. Is pregnancy a disease?

Trisha Tilley: No, but pregnancy is a condition. CDC stands for Centers for Disease Control and Prevention.

Sarah Koski - Cornerstone: I am speaking in support of this bill. There is a public health interest in gathering this information. A lot of work has gone into this bill to protect patient and provider privacy. I have written testimony and information from other states that do report these data.

Summary of testimony presented in opposition:
Rep. Neal Kurk - Hillsborough 2: I am opposed to the bill in its present form, but with certain changes I could support it. I am concerned with protecting the privacy of both providers and women receiving abortions. Under the bill, DHHS assigns the providers identifying numbers and they report using these numbers to give them anonymity. An

employee could find the key and misuse it. My first suggestion is that you allow each provider to self identify with a 12 digit number. The chances are duplicating a 12 digit number among these providers is zero. My second suggestion is that the number that is applied to each individual female whose records are being provided to the Division of Vital Records must be determined by the provider. They are already probably doing that in their own practices, but I would make it explicit. There is good reason to keep this information confidential. Lastly, this is going to have a one time cost of $130,000 to acquire a module for existing software. In addition to that, there would be about $25,000/year of ongoing expenses that could be absorbed in the Department's budget. I usually take issue with bills that reopen the budget and in past years we've simply delayed these bills.

Senator Sanborn: If 47 other states collect this information, do you know if there is an existing model for identifying language?

Rep. Kurk: No, I do not. This was carefully worked on by both sides of the issue and a compromise was reached. From my point of view, the privacy protection needs to be in here before it goes forward, and then the financial issue needs to be addressed.

Senator Carson: The bill asks for the provider number, patient patient's use of contraception. Can you tell me why this information is necessary?

Rep. Kurk: I can't answer that, but the public health folks can. The confidential number needs to be on the form. The questions is who assigns this number and who knows what it is. My suggestion is that you make it very clear that this number is assigned by the provider and will not be known to the state.

Senator Carson: Do you believe that the Bureau of Vital Statistics is an appropriate place to keep these data, or should it go to DHHS?

Rep. Kurk: If you accept my amendment, it doesn't matter who keeps the numbers. Nobody will be able to connect the name of an individual to their number.

Devan Chaffee - ACLU NH: I am speaking in opposition to this bill. Generally, I think that when the state of NH is considering collecting additional personal information, especially information about a private medical procedure, it needs to think carefully about the financial costs and privacy risks. If you begin to collect data, there is a risk that this data will be breached. That is why both governments and corporations are moving toward a data minimization strategy. This bill goes in the opposite direction and I am concerned about some of the justifications that have been stated. This bill targets only induced abortion procedures. We don't collect these kinds of data for any other procedure, including outpatient procedures that are higher risk. Why are we singling out abortions to examine quality control measures? The Division of Vital Statistics collects a lot of information on life events, but it does not collect information on medical procedures. This bill also only focuses on induced abortions; it does not include spontaneous abortions. It is unclear to me on how these data, if you're only collecting data on induced abortions, actually gets you to a pregnancy rate. Vital

Records collects data on births and fetal deaths (the death of a fetus after 20 weeks), but it doesn't receive information on miscarriages before 20 weeks. Absent this information, it is unclear to me how this bill results in knowing what the pregnancy rate is. The bill also does not allocate the necessary funds to ensure that the data is confidential and secure. The fiscal note is very outdated. The Division of Vital Records testified that it would cost at least $130,000. It has been noted that other states collect this information on spontaneous and induced abortions. However, NH takes data privacy a lot more seriously than a majority of other states. I do believe others have put a tremendous amount of work into this bill, but I am still concerned with the privacy risks. These data would be held for up to 3 years. I think it is important to note that there is information on abortion rates in NH. Clinics throughout the state voluntarily provide aggregate data in regards to abortion rates in their facilities and the Guttmacher Institute produces public reports.

Senator Sanborn: You testified that fetal deaths are only a death after 20 weeks. How do other states define death before 20 weeks?

Devan Chaffee - ACLU NH: I believe the terminology is "spontaneous abortion". The definition of "fetal death" is taken from NH law, which is reported already to Vital Records. I am sure there are a variety of other ways this can be defined.

Senator Avard: If this bill did pass, would you want spontaneous abortions included in Vital Statistics?

Devan Chaffee: I think it would be an improvement to the bill.

Senator Avard: Rep. Kurk brought up some amendments to further protect privacy- do you agree with those?

Devan Chaffee: I would be open to looking at whatever suggestions that Rep. Kurk brought forward. The bottom line is that, when I look at the reasons on why we need this information, they don't seem to justify the potential risks. Are we really concerned about quality control? Are we really trying to get pregnancy statistics? Are we even getting an accurate number? Even with Rep. Kurk's proposed amendments, I am not sure if it would justify the financial expense and security risks.

Senator Avard: A colonoscopy is not the same as an abortion because we are using the word death. Would you agree that's what makes it unique?

Devan Chaffee: I think there is a moral, religious question at the heart of that question where we may not necessarily agree. From my perspective, abortion is a medical procedure and should be treated as such. It is a decision a woman is making in consultation with her physician. Why aren't vasectomies included in this bill? It is another procedure that would impact the procreation process. By singling out this procedure, it is stigmatizing the women experiencing it.

Senator Kelly: If the purpose of this bill is to know the number of pregnancies in the state, can we use the aggregate number we receive from the clinics that perform these procedures?

Devan Chaffee: Yes, if you're looking for an overall pregnancy rate in the state, that information would be sufficient.

Senator Kelly: In this bill, information regarding a patient's use of contraception would be collected. Their partner is not mentioned. It is limited only to women, which makes me question the intent of the bill. Would you agree that when we're talking about contraception, we're talking about men and women?

Devan Chaffee: This bill is only concerned about women getting this procedure. This is no counterpart for collecting this information from men.

Senator Sanborn: Are we already collecting this information at the Department of Insurance?

Devan Chaffee: That's a very good question. Why do we need to create a new, expensive module at Vital Records solely to collect information on induced abortion procedures?

Neutral Information Presented:
Steven Warts - Division of Vital Records: We currently have an automated web-based system that we use to collect vital data throughout the state. We have an extensive automated system that has worked very well and is the model for other states. Currently, we collect data on NH residents and make it available to DHHS through a memorandum of understanding. This bill would fit right into that. I wouldn't need to know who the individuals are or what they are doing, we would just supply the technology and gather the information. We initially had no request to produce a fiscal note. Our vendor gave us an estimate of $130,000 as a one-time cost to build the module.

Fiscal Note: See fiscal note dated 02/25/15.

Future Action: Pending

KEF
Date Hearing Report completed: March 15, 2016

Speakers

Senate Health and Human Services Committee: Sign-In Sheet

Date: 03/08/2016 Time: 1:50 PM Public Hearing on HB 629-FN

HB 629-FN relative to induced termination of pregnancy statistics.

Name	Representing	Support	Oppose	Speaking? Yes	Speaking? No
		☐	☐	☐	☐
✓ Tricia Tilley + John Williams	DHHS	☑	☐	☑	☐
✓ Sarah Koski	Cornerstone policy	☑	☐	☐ (struck)	☐
✓ Devon Chaffee	ACLU-NH	☐	☑	☑	☐
Jennifer Martin	Roman Catholic Diocese of Manchester	☑	☐	☐	☑
Sen. Gary Daniels	District 11	☑	☐	☐	☒
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Senate Health and Human Services Committee: Sign-In Sheet

Date: 03/08/2016 Time: 1:50 PM Public Hearing on HB 629-FN

HB 629-FN relative to induced termination of pregnancy statistics.

Name	Representing	Support	Oppose	Speaking?	Yes	No
✓ Rep. Kurk	Hills. 2	☐	☑	Speaking?	☑	☐
		☐	☐	Speaking?	☐	☐
		☐	☐	Speaking?	☐	☐
		☐	☐	Speaking?	☐	☐
		☐	☐	Speaking?	☐	☐
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		☐	☐	Speaking?	☐	☐
		☐	☐	Speaking?	☐	☐

Senate Health and Human Services Committee: Sign-In Sheet

Date: 03/08/2016 Time: 1:50 PM Public Hearing on HB 629-FN

HB 629-FN relative to induced termination of pregnancy statistics.

Name	Representing	Support	Oppose	Speaking?	Yes	No
✓ Stephen Wurtz	Dept of State Vital Recd	☐	☐	Speaking?	☑	☐
		☐	☐	Speaking?	☐	☐
		☐	☐	Speaking?	☐	☐
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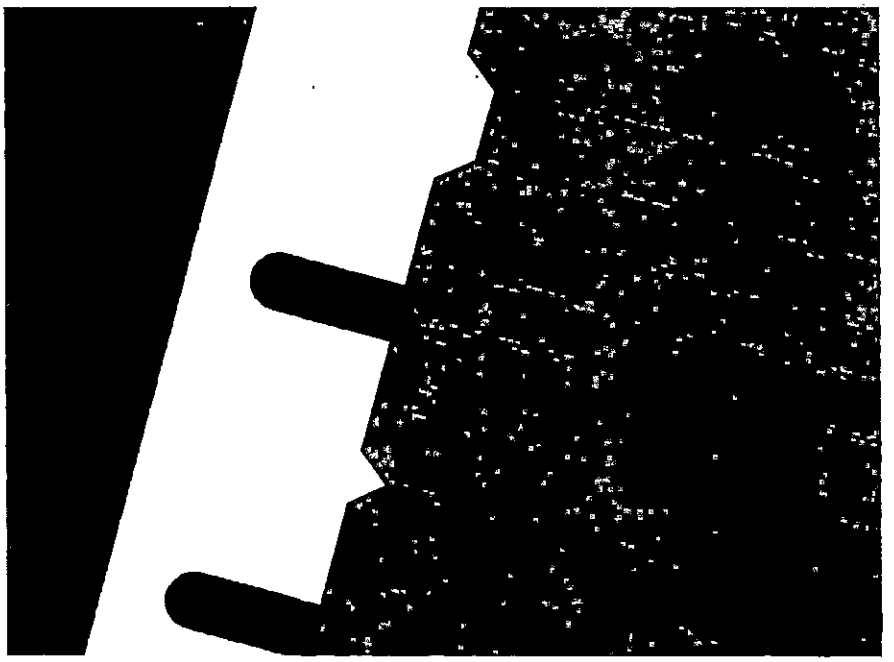
		☐	☐	Speaking?	☐	☐
		☐	☐	Speaking?	☐	☐

Testimony

Info from DHHS - HB629

Handbook on the Reporting of Induced Termination Of Pregnancy

Reprinted from 1988, Includes Revised Instructions and Reporting Form, 1997



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

Hyattsville, Maryland
April 1998
DHHS Publication No. (PHS) 98-1117

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Preface

This handbook is prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and contains instructions for persons with responsibilities for completing and filing reports of induced terminations of pregnancy (induced abortions). It pertains to the 1989 revision of the U.S. Standard Report of Induced Termination of Pregnancy as modified in 1996 by the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion and the 1992 revision of the *Model State Vital Statistics Act and Regulations*. This handbook is intended to serve as a model for adaptation by any vital statistics registration area.

Other handbooks available as references on preparing and registering vital records are:

- *Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting*
- *Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting*
- *Physicians' Handbook on Medical Certification of Death*
- *Funeral Directors' Handbook on Death Registration and Fetal Death Reporting*
- *Guidelines for Reporting Occupation and Industry on Death Certificates*
- *Handbook on Marriage Registration*
- *Handbook on Divorce Registration*

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Contents

Introduction

Purpose

This handbook is designed as an aid to acquaint hospital and clinic personnel, physicians, and others with responsibilities related to completing and filing reports of induced termination of pregnancy (induced abortion). Background information is included on the importance of these documents for statistical purposes and specific instructions for recording entries.

The purpose is to achieve improved reporting by promoting better understanding of the forms and of the uses of information entered on them.

Although State laws vary in specific requirements, generally the person in charge of the institution or facility where the induced abortion is performed has the overall responsibility for obtaining the required data, preparing the report, and filing the report with the State registrar. For abortions performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for preparing and filing the report.

Importance of induced termination of pregnancy reporting

Reports of induced termination of pregnancy are not legal records and are not maintained permanently in the files of the State office of vital statistics. However, the data they provide are very important from both a demographic and a public health viewpoint.

In January 1973, the U.S. Supreme Court ruled that the restrictive abortion laws in two States were unconstitutional and that, within the first two trimesters after conception, whether an abortion was to be performed or not was a matter between the woman and her doctor (Roe v. Wade, 410 U.S. 113 (1973); and Doe v. Bolton, 410 U.S. 179 (1973)). The net result of this ruling is that induced abortion under these criteria is legal in all States. In July 1976, the Supreme Court ruled that it is legal for States to require the reporting of certain information about induced abortions performed in that State (Planned Parenthood of Central Missouri v. Danforth, 96 Supreme Court 2831 (1976)). As a result of these two rulings, many States have established mandatory induced abortion reporting systems.

Data from reports of induced termination of pregnancy provide unique information on the characteristics of women having induced abortions. Uniform annual data of such quality are nowhere else available. Medical and health information is provided to evaluate risks associated with induced abortion at various lengths of gestation and by the type of abortion procedure used. Information on the characteristics of the women is used to evaluate the impact that induced abortion has on the birth rate, teenage pregnancy, and out-of-wedlock births. The data also help measure the role that induced abortion plays in birth prevention as compared with contraception. Because these abortion data provide information necessary to promote and monitor health, it is important that the forms be completed carefully.

State reporting requirements

In those States requiring the reporting of information on induced abortions, various methods are used to collect the data. Some States include induced abortion reporting as a part of their fetal death reporting system by collecting additional information on induced terminations on their fetal death report. A majority of the States use a separate form, usually called Report of Induced Termination of Pregnancy, for the reporting of induced abortions. In a few States, a combination system is used whereby induced abortions above a certain gestational age are reported on the fetal death report and those below that gestational age are reported on the induced termination of pregnancy report. However, regardless of the reporting system used, all States with reporting systems require the reporting of all induced abortions regardless of length of gestation.

Because of the variations that exist from State to State, it is imperative that those persons having responsibilities in the reporting of induced abortions familiarize themselves with the procedures and forms used in their State.

Live birth

Although unlikely, the induced abortion procedure may result in a live birth. Should this occur, the report of induced termination of pregnancy is not to be completed and filed. Rather, a certificate of live birth is to be prepared for the infant. In the event the infant should later die, a death certificate would also have to be prepared and filed.

U.S. Standard Report of Induced Termination of Pregnancy

The National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services has historically provided leadership and coordination in the development of the

Standard Report of Induced Termination of Pregnancy to serve as a model for use by States. This report has been revised periodically in collaboration with State health officials, registrars, and statisticians; Federal agencies; local registrars, and medical record personnel. In these revisions, each item is evaluated thoroughly for its registration, statistical, health, and research value.

In recent years, responsibility for the collection of abortion data from the official files of the States has rested with the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. In 1996, in response to the emerging use of medical procedures to induce abortion, the Division of Reproductive Health, in consultation with a working group of experts, revised Item 15: *Type of Termination Procedure.* The instructions for completing several sections of the form were also revised at this time. This Handbook reflects those revisions.

Each State is encouraged to adopt the recommended standard report as a means of developing a uniform national induced abortion reporting and statistics system. Although many States use the recommended standard report, some States modify it to comply with State laws and regulations or to meet their own particular needs for information.

State health department

The State health department administers the induced termination of pregnancy reporting system under the laws and regulations of the State. The State health department is responsible for developing forms and procedures and for ensuring adherence to the requirements of the laws and regulations. It also publishes statistical data derived from the reports of induced termination of pregnancy it receives.

Local registrar

Generally, the Report of Induced Termination of Pregnancy is filed directly with the State registrar. In a few States, however, these reports are filed with the local registrar who then forwards them to the State registrar.

Confidentiality

The Report of Induced Termination of Pregnancy is designed to collect information for statistical and research purposes only. These reports are not maintained permanently in the official files of the State health department. The data that are gathered from these reports are presented in aggregate statistics, not individually, so that specific individuals may not be identified.

Hospitals, clinics, and physicians are assured that extensive legal and administrative measures are used to protect individuals from unauthorized disclosure of personal information contained on the reporting form.

Specific responsibilities

Hospital or clinic

The hospital, clinic, or other institution or facility where the induced abortion is performed is responsible for obtaining the necessary data, completing the form, and filing it with the State registrar within the time period specified by law. To ensure the proper performance of these responsibilities, it is preferable that one staff member be given the overall responsibility and authority to see that the reports are completed and filed on time. Specifically, the hospital, clinic, or other institution should:

- Develop efficient procedures for prompt preparation and filing of the reports.
- Collect and record the information required by the report.
- Prepare a correct and legible report, making certain that every item is completed.
- File the report with the proper official within the time specified in the vital statistics laws of the State.
- Cooperate with State or local registrars concerning queries on report entries.
- Call on the State or local office of vital statistics for advice and assistance when necessary.

Physician

For induced abortions performed in a hospital, clinic, or other institution, the physician performing the abortion is responsible for providing the medical information required by the report. When an induced abortion is performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for obtaining all of the necessary data, completing the form, and filing it with the State registrar within the time period specified by law.

Part I. General instructions for completing reports

The data necessary for preparation of the induced termination of pregnancy report are obtained from the:

- Patient
- Attending physician
- Hospital or clinic records

Reports of induced termination of pregnancy are not permanent records and are used only for statistical purposes. However, the data obtained from these reports are very important from both a demographic and a public health viewpoint. Therefore, it is essential that these reports be prepared accurately. These general rules should be followed:

- File the original report with the registrar. Reproductions or duplicates are not acceptable.
- Avoid abbreviations except those recommended in the specific item instruction.
- Spell entries correctly.
- Refer problems not covered in these instructions to the State office of vital statistics.
- Use the current form designated by the State.
- Type all entries whenever possible. Do not use worn typewriter ribbons.
- If a typewriter cannot be used, print legibly in black ink.
- Complete each item following the specific instructions for that item.
- Do not make alterations or erasures.

Part II. Completing the report of induced termination of pregnancy

These instructions pertain to the 1989 revision of the U.S. Standard Report of Induced Termination of Pregnancy.

1–3 PLACE OF TERMINATION

1. FACILITY NAME *(If not clinic or hospital, give address)*

Enter the full name of the hospital or clinic where the induced termination of pregnancy occurred.

If the induced termination of pregnancy occurred in a hospital or a clinic that is physically situated within a hospital or is administratively a part of a hospital, enter the full name of the hospital.

If the induced termination of pregnancy occurred in a freestanding clinic, a clinic that is physically and administratively separate from a hospital, enter the full name of the clinic.

If the induced termination of pregnancy occurred in a physician's office or some other place, enter the number and street name or name of the place.

2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION

Enter the name of the city, town, or location where the pregnancy termination occurred.

3. COUNTY OR PREGNANCY TERMINATION

Enter the name of the county where the pregnancy termination occurred.

Item 1 provides information about the types of facilities where induced terminations are performed. Items 2 and 3 provide information that is used in the planning of health facilities and health education programs.

4. PATIENT'S IDENTIFICATION

Enter the hospital, clinic, or other patient identification number. This number must be one that would enable the facility or physician to access the medical file of this patient.

This information is used with Items 1 and 2 for querying for missing information without identifying the patient.

5. AGE LAST BIRTHDAY

Enter the age of the patient in years at her last birthday.

This information permits analysis of health risks related to length of pregnancy and type of procedure among different age groups. It is also used to study the impact of induced terminations on the fertility rates of different age groups.

6. MARRIED?

☐ Yes ☐ No Specify: _____

Check "Yes" if the patient was legally married (including separated) at the time of conception, at the time of termination, or at any time between conception and the termination. Otherwise, check "No."

This information is used to study the health risk of induced terminations by marital status. It also helps determine the impact of induced terminations on the fertility rates of married and unmarried women and aids in planning for and evaluating the effectiveness of family planning programs.

7. DATE OF PREGNANCY TERMINATION (*Month, Day, Year*)

Enter the exact month, day, and year of the pregnancy termination.

The date the pregnancy was actually terminated should be entered. This may not necessarily be the date the procedure was begun. *Exception*: For termination procedures performed by medical (nonsurgical) methods, the date of the termination should be recorded as the actual date the *initial* dosage of the medication was given—not the actual date of termination of pregnancy.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

This information is used to determine when the pregnancy termination occurred and to determine the length of gestation. Length of gestation is an essential element in the study of risks associated with induced terminations.

8a–e RESIDENCE OF PATIENT

The patient's residence is the place where her household is located. This is not necessarily the same as her "home State," "voting residence," "mailing address," or "legal residence." The State, county, and city should be that of the place where the patient actually lives. Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Residence for a short time at the home of a relative or friend is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is *not* considered temporary and should be entered as the place of residence of the patient on the report.

If the patient has been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, this facility should be entered as the place of residence.

8a. RESIDENCE—STATE

Enter the name of the State where the patient lives. This may differ from the State in her mailing address. If the patient is not a resident of the United States, enter the name of the country and the name of the unit of government that is the nearest equivalent of a State.

8b. RESIDENCE—COUNTY

Enter the name of the county where the patient lives.

8c. RESIDENCE—CITY, TOWN, OR LOCATION

Enter the name of the city, town, or location where the patient lives. This may differ from the city, town, or location in her mailing address.

8d. RESIDENCE—INSIDE CITY LIMITS? *(Yes or no)*

Enter "Yes" if the location entered in item 8c is incorporated and the patient's residence is inside its boundaries. Otherwise, enter "No."

8e. RESIDENCE—ZIP CODE

Enter the ZIP Code of the place where the patient lives.

These items provide data for the analysis of induced termination by residence of the patient. This information is used with the city and county of termination to provide information on the amount of movement occurring within a State or between States to obtain an induced termination of pregnancy. This type of information is useful in planning the location of health care facilities.

9. OF HISPANIC ORIGIN?

(Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ No ☐ Yes Specify: _____

Check "No" or "Yes." If "Yes" is checked, enter the specific Hispanic group as obtained from the patient. Do not leave this item blank. The entry in this item should reflect the response of the patient.

For the purposes of this item, "Hispanic" refers to people whose origins are from Spain, Mexico, Puerto Rico, Cuba, or the Spanish-speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality, lineage, or country in which the patient or her ancestors were born before their arrival in the United States.

There is no set rule as to how many generations are to be taken into account in determining Hispanic origin. A patient may report Hispanic origin based on the country

of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the patient considers herself to be and is not based on percentages of ancestry. Although the prompts include the major Hispanic groups of Cuban, Mexican, and Puerto Rican, other Hispanic groups can also be identified in the space provided.

If a patient indicates that she is of multiple Hispanic origin, enter the origins as reported (for example, Mexican-Puerto Rican).

If a patient indicates that she is Mexican American or Cuban American, enter the Hispanic origin as stated.

This item is not a part of the Race item. A person of Hispanic origin may be of any race. Each question, Race and Hispanic origin, should be asked independently.

Hispanics comprise the second-largest minority in this country. This item provides data to measure differences in pregnancy outcome and variations in health care for people of Hispanic and non-Hispanic origin. Without collection of data on persons of Hispanic origin, it is impossible to obtain valid demographic and health information on this important group of Americans.

Some States may wish to obtain data on other groups or may have a very small Hispanic population. Therefore, they may opt to include a general Ancestry item on their report instead of a specific Hispanic origin item. Instructions for the general Ancestry item follow:

ANCESTRY—Mexican, Puerto Rican, Cuban, African, English, Irish-German, Hmong, etc. *(Specify)*

Enter the ancestry as obtained from the patient. Do not leave this item blank. The entry in this item should reflect the response of the patient.

For purposes of this item, ancestry refers to the nationality, lineage, or country in which the patient or her ancestors were born before their arrival in the United States. American Indian or Alaskan Native ancestry should be entered as such.

There is no set rule as to how many generations are to be taken into account in determining ancestry. A person may report ancestry based on the country of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the patient considers herself to be and is not based on percentages of ancestry.

Some persons may not identify with the foreign birthplace of their ancestors or with a nationality and may report "American." If, after clarification of the intent of this item, the patient still feels that she is an "American," enter "American" on the record.

If a patient indicates that she is of multiple ancestry, enter the ancestry as reported (for example, English-Scottish-Irish, Mexican American).

If she gives a religious group—such as, Jewish, Moslem, or Protestant—ask for the country of origin or nationality.

This item is not a part of the Race item. Both questions, Race and Ancestry, should be asked independently. This means that for certain groups—such as Japanese, Chinese, or Hawaiian—the entry will be the same in both items. The entry should be made in both items even if it is the same. However, an entry of "Black" or "White" should never be recorded in the ancestry item.

10. RACE

☐ American Indian ☐ Black ☐ White

☐ Other *(Specify)* _____

Check the box that describes the race of the patient. The entry in this item should reflect the response of the patient.

If the patient is not American Indian, Black, or White, check "Other" and specify the race on the line provided.

For Asian or Pacific Islanders, enter the national origin of the patient, such as Chinese, Japanese, Korean, Filipino, or Hawaiian.

If the patient is of mixed race, check "Other" and enter both races or origins.

Information on race is needed to study the impact of induced terminations on the birth, fertility, and out-of-wedlock rates of different racial groups.

11. EDUCATION *(Specify only highest grade completed)*

Elementary/Secondary *(0–12)* _____ College *(1–4 or 5+)* _____

Enter the highest number of years of regular schooling completed by the patient in either the space for elementary/secondary school or the space for college. An entry should be made in only one of the spaces. The other space should be left blank. Report only those years of school that were completed. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

Count formal schooling. Do not include beauty, barber, trade, business, technical, or other special schools when determining the highest grade completed.

This item is an important indicator of socioeconomic status of the patient. This information is used for studying the effect of induced terminations on the health and fertility of various educational and socioeconomic groups. This information is also useful in planning educational programs that address family planning.

12. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

Enter the exact date (month, day, and year) of the first day of the patient's last normal menstrual period, as obtained from the hospital or clinic record or the patient herself.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

If the exact day is unknown but the month and year are known, obtain an estimate of the day from the patient, her physician, or the medical record. If an estimate of the date cannot be obtained, enter the month and year only.

Enter "Unknown" if the date cannot be determined. Do not leave this item blank.

This item is used in conjunction with the date of termination to determine the length of gestation. Gestational age is important in evaluating the effectiveness and safety of the various termination procedures.

13. CLINICAL ESTIMATE OF GESTATION *(Weeks)*

Enter the length of gestation as estimated by the attending physician in completed menstrual weeks. Do not compute this information from the date last normal menses began and date of termination. If the attendant has not done a clinical estimate of gestation, enter "None." Do not leave this item blank. *Exception: For termination procedures performed by medical (nonsurgical) methods, gestational age should be recorded as the gestational age of the pregnancy on the actual date the initial dosage of medication was given.*

This item provides a check on the length of gestation as calculated from date of last normal menses. It permits the physician to report an estimate when there is doubt as to the accuracy of the length of gestation or when date of last normal menses is unavailable or misleading.

14a–d PREVIOUS PREGNANCIES (Complete each section)

14a–b LIVE BIRTHS

14a. Now living

Number ____ ☐ None

Enter the number of children born alive to this patient who are still living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are dead.

14b. Now dead

Number ____ ☐ None

Enter the number of children born alive to this patient who are no longer living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are still living.

14c–d OTHER TERMINATIONS

14c. Spontaneous

Number _____ ☐ None

Enter the number of previous pregnancies that ended spontaneously and did not result in a live born infant. This should not include induced terminations. Check "None" if the patient has had no previous pregnancies or if all previous pregnancies ended in live born infants.

14d. Induced *(Do not include current termination)*

Number _____ ☐ None

Enter the number of previous induced terminations (induced abortions) that this patient has had. Do not include this termination. Check "None" if the patient has had no previous induced terminations.

This information provides a pregnancy history and allows for insight into the use of induced terminations to limit family size. Because this item also collects information on the number of previous induced terminations, it provides some data on characteristics of women who may need alternative methods of family planning.

15. TYPE OF TERMINATION PROCEDURE

(Definitions of certain abortion procedures can be found in Appendix C.)

☐ Suction Curettage

☐ Medical (Nonsurgical), Specify Medication(s) _____

☐ Dilation and Evacuation (D&E)

☐ Intrauterine Instillation (Saline or Prostaglandin)

☐ Sharp Curettage (D&C)

☐ Hysterotomy/Hysterectomy

☐ Other (Specify) _____

Check the box that describes the procedure that actually terminated this pregnancy. Check only one box. If a procedure not listed was used, check "Other" and specify on the line provided.

This item provides information on the frequency of specific procedures and the incidence of terminations involving multiple procedures. When used in conjunction with length of gestation it provides an indication of the safety, appropriateness, and health risks of the various termination procedures at different gestational ages.

16. NAME OF ATTENDING PHYSICIAN *(Type/Print)*

Enter the full name of the attending physician. Be sure to spell it correctly and verify correct spelling. This item is used to query for missing or additional information.

17. NAME OF PERSON COMPLETING REPORT *(Type/Print)*

Enter the full name of the person completing this report.

This is the primary person who is queried for missing information on the report, although the physician is contacted in some instances.

Appendixes

Appendix A

U.S. Standard Report of Induced Termination of Pregnancy

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

U.S. STANDARD

REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

1. FACILITY NAME (If not clinic or hospital, give address)	2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION	3. COUNTY OF PREGNANCY TERMINATION
Merrywood Clinic	Louisville	Jefferson

4. PATIENT'S IDENTIFICATION	5. AGE LAST BIRTHDAY	6. MARRIED?	7. DATE OF PREGNANCY TERMINATION (Month, Day, Year)
25466	23	☐ YES ☒ NO	November 20,1997

8a. RESIDENCE-STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION	8d. INSIDE CITY LIMITS? (Yes or No)	8e. ZIP CODE
Ohio	Hamilton	Cincinnati	☒ YES ☐ NO	45202

9. OF HISPANIC ORIGIN? (Specify No or Yes – If yes, specify Cuban, Mexican, Puerto Rican, etc.)	10. RACE	11. EDUCATION (Specify only highest grade completed)	
		Elementary/Secondary (0-12)	College (1-4 or 5+)
☐ No ☒ Yes Specify: Puerto Rican	☐ American Indian ☐ Black ☒ White ☐ Other (Specify) _____	12	

12. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	13. CLINICAL ESTIMATE OF GESTATION (Weeks)	14. PREVIOUS PREGNANCIES (Complete each section)			
		LIVE BIRTHS		OTHER TERMINATIONS	
		14a. Now Living	14b. Now Dead	14c. Spontaneous	14d. Induced (Do not include this termination)
September 5, 1997	10 weeks	Number _____ ☒ None	Number _____ ☒ None	Number _____ ☒ None	Number _____ ☒ None

16. TYPE OF TERMINATION PROCEDURE (Check only one)

- ☒ Suction Curettage
- ☐ Medical (Nonsurgical), Specify Medication(s) _____
- ☐ Dilation and Evacuation (D&E)
- ☐ Intra-Uterine Instillation (Saline or Prostaglandin)
- ☐ Sharp Curettage (D&C)
- ☐ Hysterotomy/Hysterectomy
- ☐ Other (Specify) _____

18. NAME OF ATTENDING PHYSICIAN (Type/Print)	17. NAME OF PERSON COMPLETING REPORT (Type/Print)
Edmund Matthew Stone, M.D.	Julia Lynn Koval

T-0725

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES – CENTERS FOR DISEASE CONTROL AND PREVENTION – NATIONAL CENTER FOR HEALTH STATISTICS – 1997 REVISION

PHS-T008
REV. 12/97

Appendix B

Definitions of live birth, fetal death, and induced termination of pregnancy

The following definitions are included in the 1992 revision of the *Model State Vital Statistics Act and Regulations*. The definitions of live birth and fetal death conform to the definitions adopted by the Assembly of the World Health Organization.

Live birth—means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

Important—If an infant breathes or shows any other evidence of life after complete delivery, even though it may be only momentary, the birth must be registered as a live birth and a death certificate must also be filed.

Fetal death—means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

Induced termination of pregnancy—means the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and which does not result in a live birth. This definition excludes management of prolonged retention of products of conception following fetal death.

Appendix C

Definitions of induced abortion procedures

Suction curettage (Also known as vacuum aspiration)—In this procedure the cervical canal is dilated by the successive insertion of instruments of increasing diameter (dilators). When the cervix is sufficiently dilated, a flexible tube (cannula) is inserted into the uterine cavity, and the fetal and placental tissues are then removed using an electric vacuum pump.

Medical (Nonsurgical)—This nonsurgical procedure involves the administration of a medication or medications to induce an abortion. Medications (e.g., methotrexate, mifepristone, misoprostol, etc.) are used most frequently early in the first trimester of pregnancy. However, some medications (e.g., prostaglandin suppositories, injectable prostaglandins, etc.) may be administered during the second trimester of pregnancy to induce abortion. Medications may be administered orally, by injection, or intravaginally.

Dilation and evacuation (D&E)—This procedure, used most frequently in the second trimester of pregnancy (greater than or equal to 13 weeks gestation) involves opening the cervix (dilation) and primarily using sharp instrument techniques, but also suction and other instrumentation such as forceps for evacuation.

Intrauterine instillation (saline or prostaglandin)—This procedure involves either withdrawing a portion of the amniotic fluid from the uterine cavity by a needle inserted through the abdominal wall and replacing this fluid with a concentrated salt solution (known as saline instillation, saline abortion, or saline amniotic fluid exchange) or injecting a prostaglandin—a substance with hormone-like activity—into the uterine cavity through a needle inserted through the abdominal wall (known as intrauterine prostaglandin instillation). The saline instillation process induces labor, which results in the expulsion of the fetus approximately 24 to 48 hours later. The interval between prostaglandin injection and expulsion tends to be shorter than in a saline abortion.

Sharp curettage (D&C) (Also known as dilatation and curettage, D&C, or surgical curettage)—This procedure involves the dilation of the cervix as in the suction curettage procedure, although usually to a larger diameter. The fetal and placental tissues are then removed with a sharp curette.

Hysterotomy/Hysterectomy—Hysterotomy involves surgical entry into the uterus to remove a fetus. Hysterotomy is usually performed only if other abortion procedures fail or if other abortion procedures are not appropriate. Hysterectomy is a procedure in which the uterus is removed (with the fetus inside). It is usually performed only when a pathological condition of the uterus, such as fibroid tumors, warrants its removal or when a woman desires sterilization.

All definitions, except for D&E, are from *Legalized Abortion and the Public Health* (Institute of Medicine, 1975). The definition of D&E is based on NCHS consultation with the Center for Health Promotion and Education, Centers for Disease Control and Prevention.

All other procedures should be shown as "Other" and the specific procedure listed. This category includes procedures using a combination of agents, such as urea and prostaglandin, prostaglandin and oxytocin, or prostaglandin and saline.

For a list of reports published by the National Center for Health Statistics contact:

Data Dissemination Branch
National Center for Health Statistics
Centers for Disease Control and Prevention
6525 Belcrest Road, Room 1064
Hyattsville, MD 20782-2003
(301) 436-8500
Internet: www.cdc.gov/nchswww/

Info from DHHS - HB629

GUTTMACHER INSTITUTE

STATE POLICIES IN BRIEF

As of MARCH 1, 2016

Abortion Reporting Requirements

BACKGROUND: For the last four decades, the federal Centers for Disease Control and Prevention (CDC) has partnered with the states to collect aggregate statistics on abortions in the United States. States are not required to submit abortion data to the CDC, but the overwhelming majority do. To collect individual-level data, most state vital statistics agencies have designed a form that abortion providers use for reporting to the state. Typically, the form requires:

- identification of the facility at which the abortion was performed and the physician performing the procedure;
- patient's demographic characteristics (e.g., age, race, ethnicity, marital status and number of previous live births);
- gestational age; and
- abortion procedure used.

After the U.S. Food and Drug Administration approved the abortion drug mifepristone in 2000, most states adjusted their forms to include questions about medication (nonsurgical) abortion. More recently, states have reconfigured their systems so that reporting is increasingly being done via the Internet.

HIGHLIGHTS:

- 46 states require hospitals, facilities and physicians providing abortions to submit regular and confidential reports to the state.
- 8 states require providers to indicate the method of payment, such as insurance or self-pay, for the procedure.
- 27 states require providers to report postabortion complications.
- 16 states require providers to give some information about the woman's reason for seeking the procedure.
    - 10 states ask whether the abortion was performed because of a threat to the woman's health or life.
    - 7 states ask whether the abortion was performed because of rape or incest.
    - 15 states ask whether the abortion was performed because of a diagnosed fetal abnormality.
    - 9 states ask whether the abortion was performed for other reasons (e.g. the woman's economic or familial circumstances).
- 6 states require providers to report whether the fetus was viable.
- 15 states require providers to indicate if the state mandates for abortion counseling and parental involvement were satisfied.
    - 9 states require providers to report whether state-mandated counseling was provided.
    - 13 states require providers to report whether state requirements for parental involvement were met.

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CONTINUED

STATE REQUIREMENTS FOR ABORTION REPORTING

STATE	REPORTING REQUIRED	METHOD OF PAYMENT	COMPLIC-ATIONS	REASONS FOR PROCEDURE				FETUS VIABLE	MET STATE REQUIREMENT FOR:	
				Woman's Health/Life	Rape/ Incest	Fetal Abnormality	Other*		Mandated Counseling	Parental Involvement
Alabama	X†									X
Alaska	X	X				X			X	X
Arizona	X		X	X		X	X	‡		X
Arkansas	X									X
Colorado	X									
Connecticut	X		X							
Delaware	X									
Dist. of Columbia	Ω									
Florida	X†			X	X	X	X			X
Georgia	X		X						X	X
Hawaii	X†		X			X				
Idaho	X		X						X	X
Illinois	X†		X				X			
Indiana	X		X					X‡		
Iowa	X									
Kansas	X							‡		X
Kentucky	X									
Louisiana	X		X	X	X	X			X	
Maine	X									
Massachusetts	X							‡		
Michigan	X	X	X					X		
Minnesota	X	X	X	X	X	X	X		X	
Mississippi	X	X	X							
Missouri	X		X					X		
Montana	X		X					X‡		
Nebraska	X		X	X	X	X	X			
Nevada	X†									
New Hampshire	Ω	X								
New Jersey	Ω					X				
New Mexico	X									
New York	X	X	X	X		X	X			
North Carolina	X		X							
North Dakota	X		X							
Ohio	X		X							
Oklahoma	X	X	X	X	X	X	X	X‡	X	X
Oregon	X		X							
Pennsylvania	X		X					‡		
Rhode Island	X		X							
South Carolina	X								X	X
South Dakota	X	X	X	X	X	X	X		X	X
Tennessee	X†									
Texas	X							‡		
Utah	X		X	X	X	X	X	X		
Vermont	X									
Virginia	X					X				
Washington	X		X			X				
West Virginia	X			X		X			X	X
Wisconsin	X		X							X
Wyoming	X		X							
TOTAL	46	8	27	10	7	15	9	6	9	13

▼ Enforcement permanently enjoined by a court order; policy not in effect.

* States list a range of "other" reasons on their forms: elective (AZ, FL, IL, MN, SD, UT); economic (FL, MN, NE, SD); contraceptive failure or nonuse (NE); the woman's familial circumstances (NY); the woman's age (NY); "therapeutic" (UT); the woman's being HIV positive (UT); and several other reasons (OK).

† Reporting form does not specifically include medication (nonsurgical) abortion.

Ω Reporting from physician to the state on abortion procedures is voluntary.

‡ State requires provider to report reasons for abortions performed after viability (IN), after 21 weeks' gestation (KS), after 23 weeks' gestation (MA and PA) or after the second trimester (TX); AZ and MA also ask whether the abortion resulted in a live birth.

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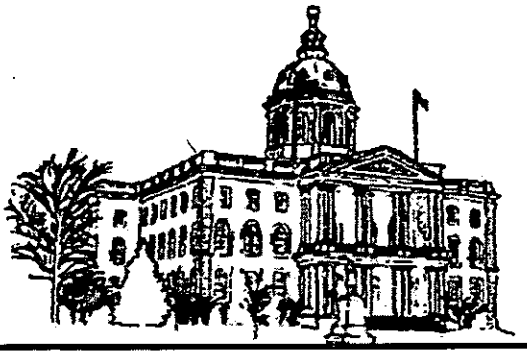
Planned Parenthood® of Northern New England



Planned Parenthood® Act. No matter what.
Planned Parenthood New Hampshire Action Fund

HB 629 - FN **relative to induced termination of pregnancy statistics**
Committee: **Senate Health and Human Services**
Date: **March 8, 2016**
Position: **BACKGROUND INFORMATION ONLY**

Incident reporting in a rural, homogenous state cannot sufficiently protect patient identity. Aggregate reporting provides a higher level of confidentiality. HB 629 requires medical facilities to report each incident of abortion. This mandates health care providers to complete a detailed and unnecessarily invasive incident report for each abortion patient. The form requires assigning each patient, facility and provider an identifying number and solicits detailed information from each patient. None of this data should be necessary to determine the basic trends or demographics such as the number of abortions performed and the geographic area from which patients originate. De-identifying the patient name is simply an inadequate protection to ensure individual anonymity. If the legislature desires a formal collection of abortion data then we believe a better approach would be for facilities to provide aggregate data, i.e. the number of abortions performed per month/quarter, the number of patients within certain age ranges and the estimated ranges of gestational age. This would be a far more secure method of patient and provider identity protection and less cumbersome on the medical and clinical personnel.

Any collection of abortion data which is being legitimately pursued for epidemiological purposes should seek reporting about the incidence of both induced and spontaneous abortions (miscarriages). Singling out induced abortion further stigmatizes and politicizes the procedure. Many states that approach this issue from public health surveillance perspective treat "abortion and miscarriage" as equally important. While HB 629 only seeks mandatory reporting of "induced" abortion data, taking a broader approach is more consistent with pursuing a public health rather than a political agenda.

The Division of Vital Records, located within the Secretary of State's office, is ill-suited to collect and manage data intended for public health purposes. DVR does not routinely operate in an environment that is HIPPA compliant, nor do they collect any other types of health related information. Placing the authority for collecting and storing abortion data within the Vital Records Division positions abortion as a "life or death" issue rather than a health issue – is a troublesome designation.

HB 629 risks disclosure of the identity of health care providers who provide abortions. The handling of confidential patient and provider information is subject to failure by the government. New Hampshire is state with a strong tradition of respecting individual privacy and distrusting government with the role of accumulating and storing personal information. This should raise heightened concern with regard to abortion data and provider information in the possession of a state agency. The threats of violence directed at abortion providers and medical facilities that offer abortion are very real and can be deadly. No state agency should be able to accumulate and retain a list or data file containing the identities and professional practice locations of abortion providers. This bill does not allocate any new funding to either the Division of Vital Records or the DHHS for the cyber security or personnel required to thoughtfully implement these new functions. The legislature cannot expect them to absorb this new burden without jeopardizing the safety and privacy of patients and providers.

Cornerstone
RESEARCH - ACTION - COMPASSION

HB 629
Sarah Koski
Political Director
Cornerstone Policy Research

House Bill 629 would allow the State to collect and review statistical information regarding abortion procedures in our State. We believe that having State specific statistics would be a positive move for New Hampshire, allowing resources, educational programs and support to be used more effectively. New Hampshire currently collects data and statistics on children's oral health, obesity, outpatient emergency visits and diabetes just to name a few examples. This information is collected and used to ensure that New Hampshire is spending its resources wisely and efficiently.

Furthermore, this bill has been carefully drafted over summer work sessions after being retained by the House HHS committee. Much effort was put into the details of what information should be collected, House Bill 629 carefully balances the needs of the State, ensuring that the information gathered does indeed have statistical value and that the privacy of the patients,providers and facilities are ensured.

In close I would ask that you support House 629.

Thank you for your time

Sarah Koski - HB629

GUTTMACHER INSTITUTE

STATE POLICIES IN BRIEF

As of MARCH 1, 2016

Abortion Reporting Requirements

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Arizona	X		X	X		X	X	‡		X
Arkansas	X									X
Colorado	X									
Connecticut	X		X							
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Dist. of Columbia	Ω									
Florida	X†			X	X	X	X			X
Georgia	X		X						X	X
Hawaii	X†		X			X				
Idaho	X		X						X	X
Illinois	X†		X				X			
Indiana	X		X					X‡		
Iowa	X									
Kansas	X							‡		X
Kentucky	X									
Louisiana	X		X	X	X	X			X	
Maine	X									
Massachusetts	X							‡		
Michigan	X	X	X					X		
Minnesota	X	X	X	X	X	X	X		X	
Mississippi	X	X	X							
Missouri	X		X					X		
Montana	X		X					X‡		
Nebraska	X		X	X	X	X	X			
Nevada	X†									
New Hampshire	Ω	X								
New Jersey	Ω					X				
New Mexico	X									
New York	X	X	X	X		X	X			
North Carolina	X		X							
North Dakota	X		X							
Ohio	X		X							
Oklahoma	X	X	X	X	X	X	X	X‡	X	X
Oregon	X		X							
Pennsylvania	X		X					‡		
Rhode Island	X		X							
South Carolina	X								X	X
South Dakota	X	X	X	X	X	X	X		X	X
Tennessee	X†									
Texas	X							‡		
Utah	X		X	X	X	X	X	X		
Vermont	X									
Virginia	X					X				
Washington	X		X			X				
West Virginia	X			X		X			X	X
Wisconsin	X		X							X
Wyoming	X		X							
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Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Tuesday, May 3, 2016

THE COMMITTEE ON Health and Human Services

to which was referred **HB 629-FN**

AN ACT relative to induced termination of pregnancy statistics.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS

BY A VOTE OF: 3-2

Senator Kevin Avard
For the Committee

Kelly Flathers 271-3091

HEALTH AND HUMAN SERVICES

HB 629-FN, relative to induced termination of pregnancy statistics.
Ought to Pass, Vote 3-2.
Senator Kevin Avard for the committee.

New Hampshire General Court - Bill Status System

Docket of HB629

Docket Abbreviations

Bill Title: relative to induced termination of pregnancy statistics.

Official Docket of **HB629**:

Date	Body	Description
1/8/2015	H	**Introduced** and Referred to Health, Human Services and Elderly Affairs; **HJ 12**, PG. 233
2/3/2015	H	Public Hearing: 2/10/2015 2:15 PM LOB 206-208
2/18/2015	H	Executive Session: 2/17/2015 LOB 205
2/18/2015	H	Retained in Committee
5/12/2015	H	Retained Bill - Full Committee Work Session: 5/19/2015 10:30 AM LOB 205
9/2/2015	H	Retained Bill - Subcommittee Work Session: 9/8/2015 12:15 PM LOB 205
9/22/2015	H	Retained Bill - Subcommittee Work Session: 9/29/2015 12:30 PM LOB 205
9/29/2015	H	Retained Bill - Full Committee Work Session: 11/5/2015 10:00 AM LOB 205
9/29/2015	H	Retained Bill - Subcommittee Work Session: 10/21/2015 11:00 AM LOB 205
10/21/2015	H	Subcommittee Work Session: 11/5/2015 9:30 AM LOB 205
10/22/2015	H	Executive Session: 11/5/2015 1:00 PM LOB 205
11/12/2015	H	Committee Report: Ought to Pass with Amendment **#2015-2551h** for Jan 6 (Vote 12-1; CC); **HC 67**, PG. 8
1/6/2016	H	Amendment **#2015-2551h**: AA VV 01/06/2016 **HJ 4** P. 44
1/6/2016	H	**Ought to Pass with Amendment** 2551h: MA VV 01/06/2016 **HJ 4** P. 44
2/22/2016	S	Introduced 02/18/2016 and Referred to Health and Human Services; **SJ 6**
3/3/2016	S	Hearing: 03/08/2016, Room 101, LOB, 01:50 pm; **SC9**
5/3/2016	S	Committee Report: Ought to Pass, 05/05/2016; **SC 17**
5/5/2016	S	Ought to Pass: **RC** 12Y-12N, MF; 05/05/2016; **SJ 16**
5/5/2016	S	Sen. Bradley Moved Laid on Table, MA, VV; 05/05/2016; **SJ 16**
5/5/2016	S	No Pending Motion; 05/05/2016 **SJ 16**

NH House NH Senate

Other Referrals

HB 629

COMMITTEE REPORT FILE INVENTORY

__X__ ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE AIDE AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

__X__ **DOCKET (Submit only the latest docket found in Bill Status)**

__X__ **COMMITTEE REPORT**

__X__ **CALENDAR NOTICE**

__X__ **HEARING REPORT**

__X__ **PREPARED TESTIMONY AND OTHER SUBMISSIONS HANDED IN AT THE PUBLIC HEARING**

__X__ **SIGN-UP SHEET(S)**

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

____ - AMENDMENT # _____ ____ - AMENDMENT # _____

____ - AMENDMENT # _____ ____ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

__X__ AS INTRODUCED __X__ AS AMENDED BY THE HOUSE

____ FINAL VERSION ____ AS AMENDED BY THE SENATE

__N/A__ **OTHER (Anything else deemed important but not listed above, such as amended fiscal notes):**

PLEASE INCLUDE THE COMMITTEE OF CONFERENCE REPORT HERE IF IT IS SIGNED BY ALL.

DATE DELIVERED TO SENATE CLERK

8/1/16

BY:

Kelly Flathers

COMMITTEE AIDE