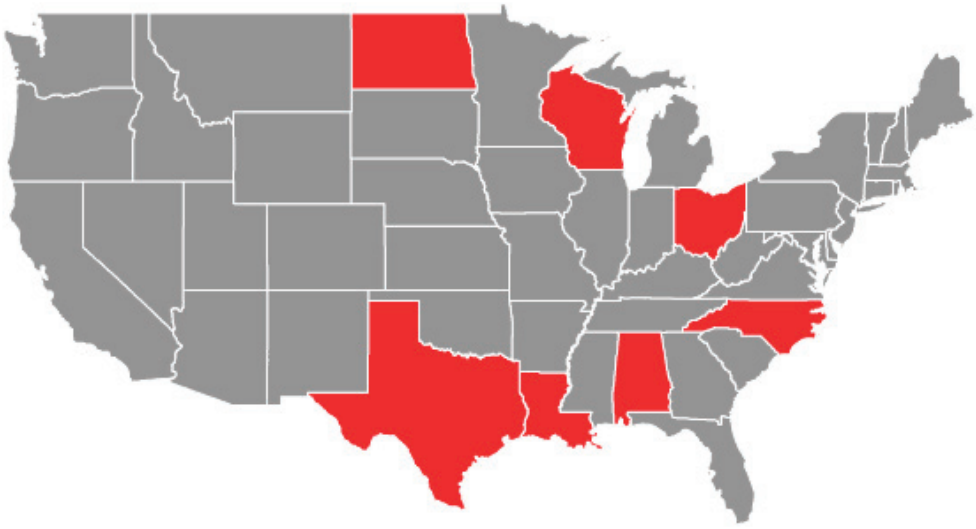
THE STATE OF THE STATES: TARGETED REGULATION OF ABORTION PROVIDERS IN 2013



ALABAMA: HB 57 is an omnibus bill that, among other provisions, requires any health care provider who offers abortion care to do so in a facility that meets extensive, medically unnecessary facility and construction requirements, and mandates that doctors maintain admitting privileges at a local hospital. The ACLU and Planned Parenthood challenged the hospital admitting privileges requirement in federal court. In June 2013, the hospital admitting privileges requirement was preliminarily enjoined.

LOUISIANA: SB 90 is an omnibus bill that, among other provisions, allows physicians to provide abortions only if they have completed or are currently enrolled in a residency program for either family medicine or obstetrics and gynecology, a medically unnecessary requirement that unfairly targets providers of abortion care.

NORTH CAROLINA: SB 353 is an omnibus law that, among other provisions, requires the Department of Health and Human Services to revisit its current regulations of abortion facilities and empowers the department to impose extensive, medically unnecessary facility and construction requirements on abortion care providers in the state.

NORTH DAKOTA: SB 2305 requires any physician who provides abortions in North Dakota to have admitting privileges at a local hospital, a law that the legislature passed with the clear intention of closing down the one remaining abortion clinic in the state. There is no medical reason to require such privileges; no other physician who provides office-based surgery is required to have them. The Center for Reproductive Rights challenged the law in state court. In July 2013, the law was temporarily **enjoined.**

OHIO: HB 59 is a budget bill that was amended to require ambulatory surgical facilities that perform abortions to have a transfer agreement with a local hospital. However, the law makes it nearly impossible for facilities to obtain the required agreement, because the bill prohibits public hospitals from providing it and contains a burdensome variance process. The ACLU of Ohio has filed a lawsuit against the restrictions.

TEXAS: HB 2 is an omnibus bill that, among other provisions, imposes extensive, medically unnecessary facility and construction criteria, and requires that every physician who provides abortions obtain admitting privileges at a local hospital. There is no medical reason to require such privileges; no other physician who provides office-based surgery is required to have them. The Center, with the ACLU and Planned Parenthood, challenged the hospital admitting privileges requirement in federal court. Women are harmed every day this admitting privileges criteria remain in effect. Learn more about the case **here**.

WISCONSIN: SB 206 is an omnibus bill that, among other provisions, requires abortion providers to maintain admitting privileges at a local hospital. There is no medical reason to require such privileges; no other physician who provides office-based surgery is required to have them. Planned Parenthood and the ACLU challenged the law in federal court. In August 2013, the law was preliminarily enjoined.

TARGETED REGULATIONS OF ABORTION PROVIDERS (TRAP)

Attempts to impose burdensome and medically inappropriate requirements on abortion providers, making it more difficult for women to exercise their constitutional right to choose abortion, are frequently referred to as targeted regulations of abortion providers, or TRAP laws. These types of laws make the delivery of health care services prohibitively expensive and place unnecessary restrictions on the qualifications of providers who perform abortions, in an attempt to prevent them from being able to provide abortion care.

TRAP bills can take the form of requiring facilities where abortions are provided to meet medically inappropriate construction requirements that can be prohibitively costly and have no impact on patient health or safety. Others require abortion providers to have admitting privileges at a local hospital, despite the lack of a medical reason to require such privileges and the fact that other physicians who provide office-based surgery are not required to have them. There are many reasons why physicians, including some abortion providers, do not have such privileges. One is that abortion is one of the safest medical procedures available in the United States. And hospitals are often reluctant or unwilling to grant privileges to physicians who do not regularly admit patients to their hospital.

In 2013, TRAP bills passed in seven states—Alabama, Louisiana, North Carolina, North Dakota, Ohio, Texas, and Wisconsin—and served as a catalyst for an energized and engaged movement of people who are outraged by the relentless state legislative attacks on abortion care.

THE IMPACT OF TARGETED REGULATIONS ON ABORTION PROVIDERS

Reproductive health care services are among the safest and mostly commonly sought forms of care in the United States. Health centers that specialize in reproductive care are already among the most rigorously regulated and scrutinized health care providers. TRAP laws differ from warranted safety guidelines and regulations because they are explicitly devised as political tools to deter abortion providers from practicing abortion care, to make abortions more costly for women, and to force abortion clinics to close their doors.

There are four states with only one abortion provider. For those states, in particular, where access is most limited, TRAP regulations can serve as a backdoor ban on abortion.

These restrictions don't do anything to improve patient care or safety—in fact they drive up health care costs for patients and drive providers of quality health care out of practice. Contrary to the claims of proponents of these measures, TRAP laws harm women's health and undermine their safety. Politically motivated regulations that make it more difficult for clinics to provide high-quality care only make it harder for people to access essential reproductive health services, including lifesaving cancer screenings, contraception, STD prevention and treatment, and continued access to safe and compassionate abortion care.

As we clearly saw in Texas in 2013, TRAP laws result in clinics closing – and we know what happens when women can't access the safe abortion care they need. A woman without a nearby clinic may be forced to travel hundreds of miles to get an abortion, driving up her costs not just financially but also emotionally. Transportation, accommodations, child care, time off work, and the chance that she may be forced into having a later abortion can all add up to placing safe abortion care beyond a woman's reach. And when clinics close, not only abortion care but other reproductive health care is lost.

Additionally, when clinics close, some women may take matters into their own hands. Study after study by national and international experts have shown that restrictions on abortion don't reduce its frequency, but rather increase women's reliance on illegal and unsafe abortions.

Opponents of reproductive rights know they can't ban abortion outright, so instead they put as many barriers as they can between women and their ability to exercise their rights—under the guise of protecting women's health. In reality, TRAP laws clearly threaten the health of women seeking abortions and deprive women of their constitutionally protected right to decide whether and when to have children.

DRAW THE LINE

In 2012, the Center launched the Draw the Line campaign with the express purpose of putting the rampant attacks on women's reproductive health care—like those described above—on the entire nation's radar. Nearly 300,000 people have signed the Bill of Reproductive Rights at **www.DrawtheLine.org**, sending politicians a loud and clear message that reproductive rights are fundamental human rights, and must be protected from extremist politicians. Visit **www.DrawtheLine.org** to add your voice.

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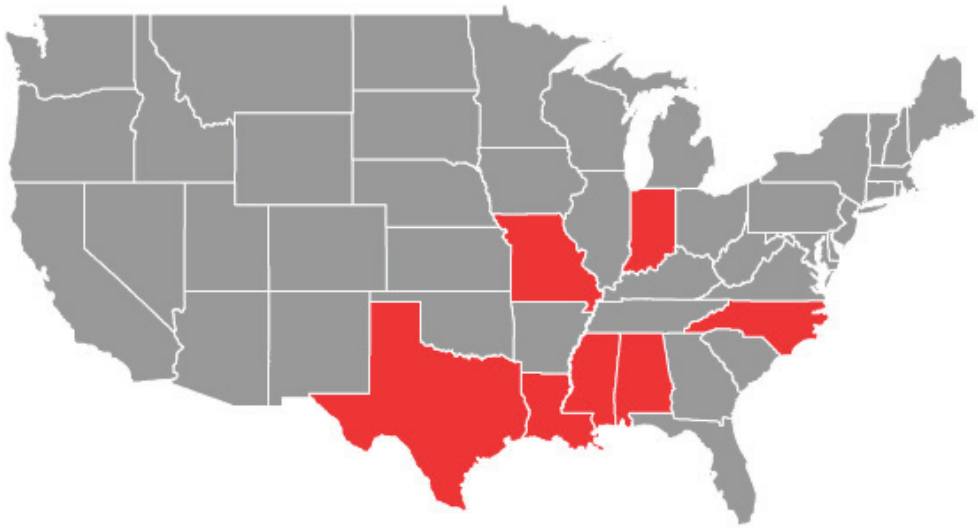
THE STATE OF THE STATES: ATTACKS ON MEDICATION ABORTION ACCESS IN 2013



ALABAMA: HB 57 targets women's access to care by prohibiting the use of telemedicine to provide medication abortion. For rural and low-income individuals, telemedicine has become a critical delivery method for health care, enhancing the accessibility of quality care for many people in the United States. Abortion care should not be exempted from this vital expansion of health care provision. However, other sections of HB 57 are the subject of a federal lawsuit filed by the ACLU and Planned Parenthood.

INDIANA: SB 371 requires patients seeking medication abortion to have an ultrasound and prohibits providing medication abortion through telemedicine. The law also requires facilities where only medication abortion is provided to comply with the same onerous and medically unnecessary physical plant requirements that apply to facilities that provide surgical abortion. The ACLU and Planned Parenthood filed a challenge to the physical plant requirements in federal court, and that provision is enjoined.

LOUISIANA: SB 90 prohibits the use of telemedicine for medication abortion. For rural and low-income individuals, telemedicine has become a critical delivery method for health care, enhancing the accessibility of quality care for many people in the United States. Abortion care should not be exempted from this vital expansion of health care provision.

MISSISSIPPI: SB 2795 prohibits the provision of medication abortion through telemedicine. For rural and low-income individuals, telemedicine has become a critical delivery method for health care, enhancing the accessibility of quality care for many people in the United States. Abortion care should not be exempted from this vital expansion of health care provision.

MISSOURI: HB 315 prohibits physician assistants from providing medication abortions, which only clarifies and reinforces an existing policy prohibiting physician assistants from performing any abortions. HB 400 prohibits the provision of medication abortion through telemedicine, a critical delivery method for health care for rural and low-income women. Abortion care should not be excluded from this vital expansion of health care provision.

NORTH CAROLINA: SB 353 is an omnibus bill that, among other restrictions, prohibits the provision of medication abortion through telemedicine. For rural and low-income individuals, telemedicine has become a critical delivery method for health care, enhancing the accessibility of quality care for many people in the United States. Abortion care should not be exempted from this vital expansion of health care provision.

TEXAS: HB 2 is an omnibus bill that, among other provisions, requires health care providers to follow an outdated regimen for the provision of medication abortion and mandates that only a doctor may administer the medication. The net effect is that women will have to make two additional visits to their doctor, a severe hardship for the many women not close to a provider. The medically unnecessary restrictions on medication abortion are currently in effect. The Center, with the ACLU and Planned Parenthood, challenged the medication abortion restrictions. **See the brief to learn more about the Center's legal battle to stop this law.**

HOW STATES ARE RESTRICTING MEDICATION ABORTION

Since the Food and Drug Administration (FDA) approved medication abortion in 2000, more than 1.4 million women in the United States have chosen to use this method to end a pregnancy. It is a safe, less invasive, and more private method of ending a pregnancy in its earliest stages, and is done in consultation with health care provider.

Restrictions on medication abortion have taken several different shapes in recent years. In 2013, anti-abortion legislators targeted women's access to medication abortion by proposing legislation in at least 10 states that would make it more difficult for women to access this early method of abortion care.

One way that has become prevalent requires a physician to be physically present, thereby prohibiting the use of telemedicine for abortion. For rural and low-income individuals, telemedicine has become a critical delivery method for many kinds of health care, enhancing the accessibility of quality care for many people in the United States. In the context of medication abortion, a rural patient is able to visit a local health clinic and be examined by an on-site health care professional, then talk with a physician working remotely who can review her health records, answer her questions, and provide the necessary medication. This protocol represents an innovative, safe approach to improving abortion access for rural women.

Seven states—Alabama, Indiana, Louisiana, Mississippi, Missouri, North Carolina, and Texas—enacted laws that ban the use of telemedicine for medication abortion. North Carolina's bill could also limit medication abortion provision by requiring it to be dispensed in a building that meets extensive facility and construction requirements meant for surgical centers, a policy that is completely medically unnecessary.

Another form of medication abortion restrictions that some states are advancing is a requirement that it be provided using an outdated protocol, one that has since been supplanted in favor of an evidence-based regimen that is safer, more effective, and less expensive. In 2013, Texas passed an omnibus bill that, among other provisions, requires health care providers to follow the outdated regimen for the provision of medication abortion and mandates that only a doctor may administer the medication. Current Texas law already requires most women to make a separate trip to the clinic for a state-mandated ultrasound prior to their abortion procedure. The law forces women to make two additional visits to a clinic for medication abortion – for a second medication dosage and for mandatory follow up – resulting in a combined total of four mandatory visits. The Center for Reproductive Rights along with our allies challenged the law in federal court, but it remains in effect while litigation is pending.

A total ban on medication abortion has been found unconstitutional **in a recent decision**. In 2011, the Center filed a legal challenge, *Oklahoma Coalition for Reproductive Justice et al., v. Terry Cline, et al.,* to block an Oklahoma state law that would have prohibited the provision of medication abortion entirely in the state. The law was permanently struck down by a district court judge, and the Oklahoma Supreme Court later upheld the lower court's decision. However, state officials petitioned the U.S Supreme Court, which agreed to review the case, but asked that the Oklahoma Supreme Court first give a definitive ruling about the scope of the law. The Oklahoma Supreme Court ruled that the law is a complete ban on medication abortion and a ban on the most commonly used treatment for ectopic pregnancies. Following this clarification, the U.S. Supreme Court refused to hear the state's appeal in this case, ensuring women in Oklahoma have access to medication abortions and non-surgical treatment of ectopic pregnancies.

THE IMPACT OF RESTRICTIONS ON MEDICATION ABORTION

Women in the United States have been using medication abortion safely for more than a decade. In fact, when it is an available option, one in four women decides to use this method. Medical studies have shown that it is just as safe and effective as a surgical abortion, as a woman is overseen by a medical professional to whom she has access 24 hours a day, seven days a week.

Particularly for rural women, the use of telemedicine to provide safe medication abortion has been an innovative development in expanding abortion access in places where the lack of availability of abortion providers serves as a barrier to care. By banning this form of medication abortion provision, legislators are reducing access to abortion care for women purely for political purposes. This could make abortion care more difficult and more expensive to access, posing real potential threats to women's health and safety—especially those already disadvantaged. A woman's zip code should not define her access to care.

By requiring the provision of medication abortion to follow the outdated labeling protocol, extremist legislators are singling out a safe and common medical practice—known as the "off-label" use of drugs. These restrictions force doctors to administer medication in a way that counters the best practice of medicine and most recent scientific advances. According to the American Medical Association, up to 20 percent of all drugs are prescribed off-label, and up to 75 percent of medications prescribed by pediatricians are for off-label uses. Off-label use of medication is acceptable when it is based on sound science and clinical evidence. When state legislators require the outdated labeling protocol for medication abortion, they deny women the newer, evidence-based regimen for medication abortion that have been proven to be safer, more effective, and less expensive. This is not only forcing outdated health care on women, but also an unprecedented intrusion in the doctor-patient relationship and an underhanded effort to deny women their legal right to terminate a pregnancy safely, early, and in accordance with their health care providers' advice and their own wishes.

Lawmakers claim that these types of law are aimed at protecting women's health—and nothing could be further from the truth. Their real agenda is to make it so difficult for women to exercise their fundamental, constitutionally protected right to decide for themselves whether to continue or end a pregnancy that it becomes a right that exists only on paper. These laws do the very opposite of what legislators claim and will result in harm to women, depriving them of a less invasive and, in some cases, medically preferable alternative to a surgical procedure. No medical procedures other than abortion are targeted for restrictions aimed at reducing their effectiveness and increasing their expense and inconvenience. This is an assault on women's reproductive rights and health, pure and simple.

DRAW THE LINE

Politicians are making it harder, more dangerous, and more costly to have a medication abortion. Doctors know better than politicians what's right for their patients, and patients should be able to make these decisions according to their doctors' advice and expertise, not any politician's ideological agenda. In 2012, the Center launched the Draw the Line campaign with the express purpose of putting the rampant attacks on women's reproductive health care—like those described above—on the entire nation's radar. Nearly 300,000 people have signed the Bill of Reproductive Rights at **www.DrawtheLine.org,** sending politicians a loud and

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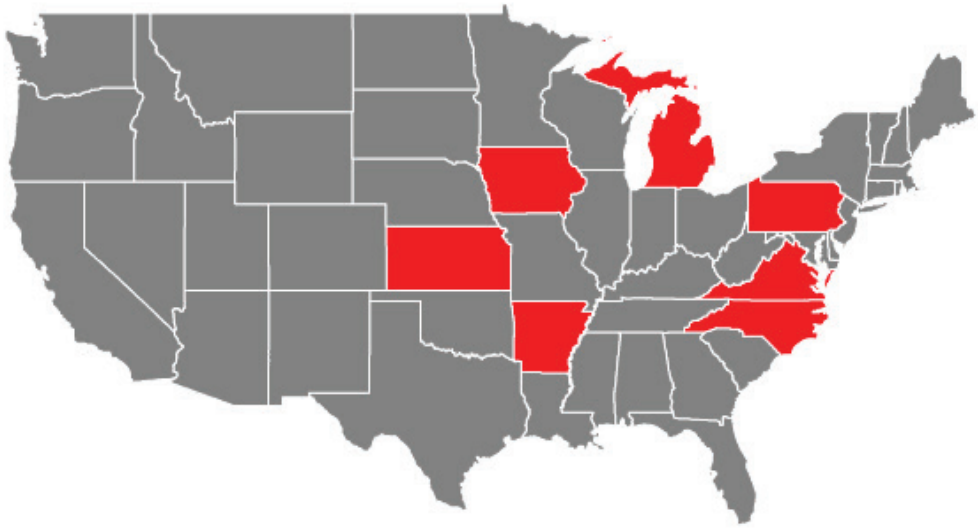
THE STATE OF THE STATES: RESTRICTIONS ON INSURANCE COVERAGE IN 2013



ARKANSAS: HB 1100 prohibits insurance coverage for abortion in plans sold on the state health care exchange, with an exception for coverage in cases when a woman's life is endangered or the pregnancy resulted from rape or incest. The bill permits optional abortion coverage outside of the exchange but subjects insurers to complicated rules and procedures, making it unlikely that insurers will actually offer such coverage in the market.

IOWA: SB 446 provides unprecedented discretion to the governor of Iowa to review requests for abortion coverage on a case-by-case basis and determine whether that individual woman qualifying for public insurance should be eligible for Medicaid reimbursement for abortion care. The bill also requires that women have an opportunity to view an ultrasound and receive pregnancy-options counseling in order for the abortion to be eligible for coverage.

KANSAS: HB 2253 is an omnibus bill that, among other provisions, imposes enormous tax penalties on anyone who provides, seeks, or even carries insurance coverage for abortion services. The Center challenged the entire omnibus law in state court. While the court enjoined two of the most egregious provisions of the law, these discriminatory tax penalties will **go into effect in 2014.**

MICHIGAN: IL 1, a citizen initiated bill, prohibits insurance coverage for abortion in plans sold on the state health care exchange and in the private insurance market, with an exception for coverage in cases when a woman's life is endangered. The bill permits optional abortion coverage but subjects insurers offering coverage and health care providers accepting the coverage to complicated rules and procedures, making it unlikely that women will be able to utilize insurance policies to cover abortion care.

NORTH CAROLINA: SB 353 is an omnibus bill that, among other provisions, prohibits insurance plans offered through the state health care exchange from covering abortion services unless the pregnancy is the result of rape or incest, or the life of the woman is endangered. The law also prohibits municipalities from offering insurance coverage for abortion beyond that available through the state employees' plan, which is limited to coverage for abortions necessary for the woman's life to be saved or cases of rape or incest.

PENNSYLVANIA: HB 818 prohibits insurance plans offered through the state health care exchange from covering abortion services unless the pregnancy is the result of rape or incest or the life of the woman is endangered. Whether she has private or public health insurance, every woman should have coverage for a full range of pregnancy-related care, including abortion.

VIRGINIA: HB 1900 bans insurance coverage of abortions in the state health care exchange. The bill only allows insurance coverage if a woman's life is endangered or if the pregnancy is the result of rape or incest. Whether she has private or public health insurance, every woman should have coverage for a full range of pregnancy-related care, including abortion.

HOW STATES RESTRICTED INSURANCE COVERAGE FOR ABORTION IN 2013

Multiple state and federal laws currently impose a variety of unfair limitations on insurance coverage. Since 1977, the federal government and a majority of states have banned insurance coverage for abortion care for women who qualify for public health insurance like Medicaid. Since 2010, when health care reform explicitly opened the door for states to restrict insurance coverage for abortion in health plans sold on a state's health insurance exchange, many states have moved to pass such laws. The renewed focus on how abortions are paid for and whether they are covered by insurance has energized advocates seeking to protect and expand coverage for abortion no matter what type of insurance a woman has. Unfortunately, it has also energized those who oppose abortion and are seeking to cement and expand bans on coverage of abortion care.

In 2013, five states (Arkansas, Michigan, North Carolina, Pennsylvania, and Virginia) passed legislation banning insurance coverage of abortion in health plans sold on their state health care exchanges, with limited exceptions, bringing the total number of states with this policy to 24. North Carolina further prohibited insurance coverage for abortion for people employed by municipalities in the state. In an unprecedented move, Iowa enacted a law requiring the governor to review billing for each Medicaid-eligible abortion in the state to determine whether that abortion qualifies for insurance coverage under the small number of exceptions permitted in the Medicaid program. In December, Michigan legislators approved a ban on insurance coverage for abortion in all private plans in the state, using a complicated and controversial legislative maneuver brought forth by a small minority of voters. And finally, Kansas took aim at health savings accounts and imposed tax penalties on anyone who purchased a separate rider providing insurance coverage for abortion or used health savings account funds to pay for abortion care.

EFFECTS OF RESTRICTIONS ON INSURANCE COVERAGE FOR ABORTION

Restrictions on public insurance coverage of abortion force some women to continue unwanted pregnancies, cause other women to delay abortion care at potentially increased risk to their health, and impose additional financial strains on low-income and indigent women. Women eligible for Medicaid who cannot get insurance coverage for abortion report forgoing basic necessities, borrowing money, or selling or pawning personal belongings in order to pay for an abortion. Women unable to make up for the lack of insurance coverage for the procedure are often forced to carry their unwanted pregnancy to term. Research shows that these impacts of restrictions on public insurance coverage for abortion may also apply to women with private insurance, who cannot or do not use that insurance for abortion care.

Whether she has private or public health insurance, every woman should have coverage for a full range of pregnancy-related care, including abortion. Withholding insurance coverage for needed health care in order to make it more difficult or impossible for a woman to have an abortion is unconscionable.

DRAW THE LINE

The Center for Reproductive Rights is proud to be a partner of All* Above All, which unites organizations and individuals to build support for lifting the bans that deny abortion coverage. Our vision is to restore public insurance coverage so that every woman, however much she makes, can get affordable, safe abortion care when she needs it. Learn more and take action at **www.allaboveall.org.**

You can also urge your members of Congress to support the Women's Health Protection Act, which would create stronger federal protections for the essential health care, personal decision making, and individual constitutional rights of every woman in the United States, no matter where she lives. Take action now to support this historic bill.

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THE STATE OF THE STATES:
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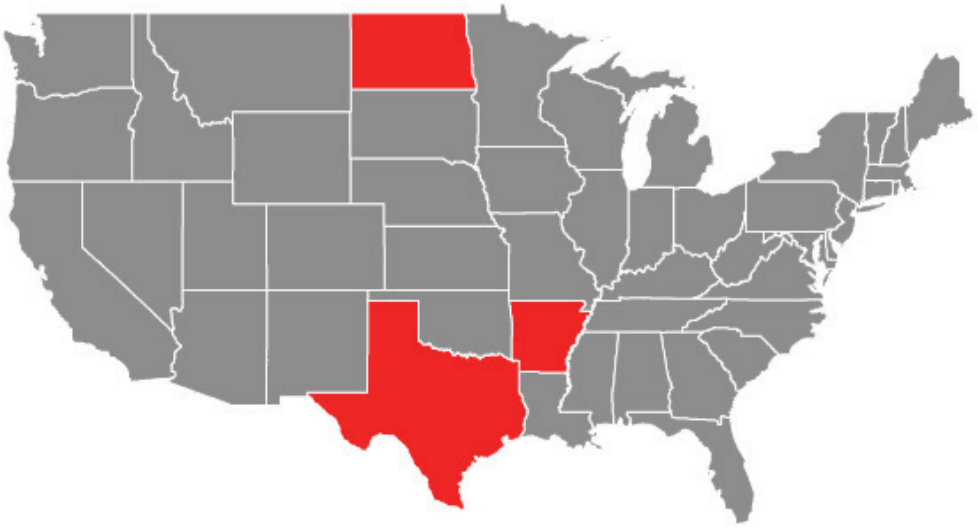

ARKANSAS: HB 1037 bans abortion after 20 weeks post-fertilization. The measure includes two exceptions for life endangerment and a narrow exception for a woman's health. The ban is currently in effect. SB 134 bans abortion at 12 weeks of pregnancy with exceptions for pregnancies resulting from rape and incest, or when the life or health of a woman is endangered. The Center, the ACLU, and the ACLU of Arkansas challenged SB 134 in federal court. In May 2013, the law was preliminarily **enjoined**, and therefore is not currently in effect.

NORTH DAKOTA: HB 1456 would ban abortion as early as six weeks of pregnancy, at the first sign of cardiac activity. This is often before many women even learn they are pregnant. The measure includes exceptions for life endangerment and a narrow exception for a woman's health. The Center challenged the law in federal court on behalf of the sole abortion provider in North Dakota. In July 2013, the law was preliminarily **enjoined**, and therefore is not currently in effect. SB 2368 bans abortion after 20 weeks post-fertilization. The measure includes exceptions if the life or health of a woman is endangered under narrow circumstances. The ban is currently in effect and is not being challenged at this time.

TEXAS: HB 2 is an omnibus bill that, among other provisions, bans abortion after 20 weeks post-fertilization. The measure includes exceptions for life endangerment and a narrow exception for woman's health and in cases of fetal anomaly. However, there are no exceptions for pregnancies resulting from rape or incest. The ban is currently in effect and is not being challenged at this time. However, other sections of HB 2 are the subject of a federal lawsuit brought by the Center for Reproductive Rights, Planned Parenthood Federation of America, the ACLU, and George Brothers Kincaid & Horton.

HOW STATES BANNED ABORTION IN 2013

Anti-abortion politicians and advocates have mounted a campaign to pass unconstitutional bans on abortion prior to viability based on gestational age. In 2013, extremist legislators introduced bans on abortion as early as six weeks in pregnancy. In fact, two states banned abortion in the first trimester: Arkansas banned abortion at 12 weeks from a woman's last menstrual period (LMP), and North Dakota banned abortion around six weeks LMP, upon detection of the first sign of cardiac activity. Each of these laws is blatantly unconstitutional and has been challenged by the Center for Reproductive Rights and our allies in federal court. Both bans have been preliminarily enjoined by a federal court.

Not content with banning abortion early in pregnancy, Arkansas and North Dakota also passed bans on abortion at 20 weeks post-fertilization. In addition, after an epic debate, Texas passed an omnibus measure which included a ban on abortion at 20 weeks post-fertilization. Overall, 11 states and one municipality considered bans on abortion at 20 weeks. Moreover, three other states proposed, but rejected, bans on abortion as early as six weeks LMP.

Since 2010, 12 bans on abortion at either 20 weeks post-fertilization age or at 20 weeks LMP (which is 18 weeks post-fertilization) have become law in Alabama, Arkansas, Arizona, Georgia, Indiana, Idaho, Kansas, Louisiana, Nebraska, North Dakota, Oklahoma, and Texas. In the three states where a 20-week ban has been challenged—Arizona, Georgia, and Idaho—the court has enjoined each law, either preliminarily or permanently. And, the United States Supreme Court recently refused to review the Arizona law which would have banned all abortions at 20 weeks—allowing a ruling from an appellate court striking the measure as unconstitutional to stand.

THE IMPACT OF ABORTION BANS

For the last four decades, the U.S. Supreme Court has consistently recognized a woman's right under the U.S. Constitution to make her own reproductive health care decisions. State attempts to take away that right by banning abortion prior to viability are a clear violation of a woman's constitutional rights.

We don't need to guess about the brutal consequences of such restrictive and extreme bans on abortion. We know that women desperate to end a pregnancy will find ways to do so — whether it is safe and legal or not.

Banning abortion at 20 weeks is not only unconstitutional and cruel, it profoundly interferes in the doctor-patient relationship. These bans fail to take into account women's highly individual medical needs and circumstances. States that ban abortion at six, 12, or 20 weeks consign women in their states to a second class of citizens, returning them to the dark days before Roe. An abortion ban at six weeks is akin to an outright ban on all abortions, since many women may not even discover they are pregnant before that time.

Because of some states' restrictions, a woman's ability to make personal decisions about her reproductive health care currently depends on her zip code. Every pregnant woman faces her own unique circumstances, challenges, and potential complications, and must be able to make her own decisions based on her doctor's advice, her personal values, and what's right for her and her family.

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