

2005 LEGISLATIVE SUMMARY

I. OVERVIEW

The state program at the Center for Reproductive Rights (the Center) tracks legislation in all fifty states that advances and restricts women's access to reproductive health care. This report gives an overview of the 2005 state legislative session. If you would like additional information or assistance with legislation relating to reproductive rights or health, please contact the Center's legislative counsel, Katherine Grainger, at Kgrainger@reprorights.org.

The 2005 legislative session concluded with the introduction of over 650 bills pertaining to abortion, contraception, and other issues affecting reproductive health. While the number of introduced bills is similar to previous sessions, the amount of bills actually enacted was substantial, with twenty-four states enacting thirty-nine laws designed to restrict access to abortion and reproductive health. On a more positive note, this year saw an increase in measures introduced to enhance access to contraception, with forty-one bills introduced and six enacted.

The majority of bills introduced this session sought to add more restrictions to existing abortion provisions. This trend was particularly prevalent in bills introduced to restrict minor's access to abortion through parental involvement laws and bills making it more difficult for women to have abortions by increasing bias counseling requirements.

Also, in 2005, we saw an increase in the introduction of bills that provide direct financial support to crisis pregnancy centers and other organizations that support abortion alternatives. Similarly, states continue to introduce legislation that allows motorists to purchase "Choose Life" license plates, which also channel funds to crisis pregnancy centers.

Finally, this session produced an incredible push to give the fetus personhood rights and protections. This included, the introduction of over 119 fetal homicide bills, six of which were enacted, that recognize the fetus as an independent victim of homicide or assault. We also tracked an increased number of bills that punish pregnant women for

their behavior during pregnancy, with five states enacting five laws that restrict women's rights for the asserted purpose of protecting the fetus.

Proactive legislation introduced during the 2005 legislative session, focused heavily on increasing access to contraception. Legislation was passed to permit pharmacists to dispense emergency contraception without a prescription, as well as to require emergency rooms to dispense EC to victims of sexual assault. Finally, proactive bills were introduced to counter the increasing trend of pharmacists who refuse to fill valid prescriptions for contraception.

Below is a more detailed summary of the 2005 session.

II. ABORTION ACCESS

A. Abortion Bans

During the 2005 session, the Center saw an increase over prior sessions in the number of bills introduced aimed at banning abortion. The Center tracked a total of forty-four bills in twenty-two states (including the territory of Guam), which would establish some type of ban on abortion; two of these bills were enacted (South Dakota and Texas)

Eight bills in four states were introduced this session that would ban abortion in all instances, except when absolutely necessary to save the life of the mother. South Dakota enacted a ban on abortion that would become effective “on the date that the states are recognized by the United States Supreme Court to have the authority to regulate or prohibit abortions at all stages of pregnancy.” Accordingly, if *Roe v. Wade* is overturned, the South Dakota law will ban abortion in all stages of pregnancy. In addition, five bills were introduced in five states that would ban abortions post-viability. In Texas a bill was enacted that outlaws abortion on a viable fetus in the third trimester. Exceptions will only be made if the viable fetus has an irreversible brain impairment, or to prevent brain damage, paralysis, or death to the pregnant woman.

The Center also tracked sixteen bills in nine states, which attempt to restrict “partial-birth abortions.” None of these bills met any success in the legislatures, which demonstrates a decline in the prevalence of such laws in comparison to recent sessions

B. Biased Counseling and Mandatory Delay

Also this session the Center witnessed a large number of bills introduced to require biased counseling and a mandatory delay before a woman can have an abortion.

In twenty-two states, thirty-seven bills were introduced to require a woman to receive state scripted information before her abortion, while another eighteen states introduced over thirty bills that would require a woman to delay her abortion for an established period of time. Two of these bills were enacted in Georgia and Oklahoma.

South Dakota amended its informed consent statute to require that women be informed in writing at least two hours before the abortion that the abortion “will terminate the life of a whole, separate, unique, living human being,” and could produce adverse mental health outcomes and death to the woman. This provision has been enjoined. In Minnesota a biased counseling/mandatory delay bill passed one legislative body before the legislature adjourned for the year.

Also this session, twenty-three fetal pain provisions were introduced in fifteen states. The majority of the bills introduced sought to require that the state’s informed consent materials be amended to include information that the fetus has the capacity to feel pain at a specified point in gestation. Arkansas, Georgia, and Minnesota enacted fetal pain provisions during the 2005 legislative session.

The new Arkansas law amends the state’s informed consent measure to require that women seeking abortions at twenty weeks gestation receive written materials produced by the state, which include information that a fetus might be able to feel pain. In Georgia, a law was enacted that requires women to be orally informed, prior to an abortion, that information about fetal pain is available on a state sponsored website. The Minnesota law requires a physician or her agent to advise a patient seeking an abortion after twenty weeks gestation about whether or not anesthesia could alleviate fetal pain.

The measure enacted in Arkansas requires a physician to administer anesthesia to the fetus upon the patient’s consent. In Minnesota, a physician must anesthetize a twenty-plus week fetus, or refer the patient to another doctor prior to an abortion, upon a patient’s request. This session, however, bills were introduced in Colorado and West Virginia that would have mandated anesthesia irrespective of a patient’s consent. Finally, South Dakota enacted a measure to study various aspects of abortion, including the potential for fetal pain.

Anti-choice forces also introduced bills that would require medically unnecessary ultrasounds before a woman can consent to having an abortion. Three states introduced five bills that would amend their informed consent requirements to include unnecessary ultrasounds. In Indiana, the governor signed a bill into law that gives a woman the opportunity to view an ultrasound image and the fetus’s heartbeat prior to obtaining an abortion.

Louisiana enacted a law that requires women seeking abortions due to rape or incest using state funds, to be offered the same “informed consent” information, without the 24-hour delay, that is required for all other abortions in the state.

C. Minor’s Access

Bills designed to restrict minors’ access to health care also dominated the 2005 legislative session, with the introduction of roughly eighty bills in thirty-six states. More often than not, these bills sought to add new requirements to pre-existing parental notice or parental consent laws, as well as change existing notice requirements to consent. We

also monitored the disturbing trend of laws attempting to remove medical emergency exceptions for minors and restricting access to a judicial bypass. In addition, five bills were introduced this session that would require a minor to have parental consent in order to access contraception.

Nine parental involvement bills were enacted in 2005. In Arkansas and Texas, legislators changed existing parental notice requirements to parental consent laws. Minors in Arkansas must now obtain notarized written consent or in-person consent from a parent or guardian before a physician can perform an abortion. In Texas, minors must obtain the written consent of one parent before having an abortion. Georgia amended the state's existing parental involvement law, removing provisions that permitted persons standing *in loco parentis* to receive notification of a minor's pending abortion. Under the new law, only a parent or guardian can receive notice or waive the mandatory 24-hour period a minor must wait after notice has been given before she can have an abortion.

Also this session, Oklahoma enacted a parental involvement law, which requires notice to one parent forty-eight hours prior to an abortion. The Florida Legislature, as a result of an amendment to the state constitution passed by the voters in 2004, enacted a parental notice requirement that requires a physician to notify a minor's parent or guardian at least forty-eight hours before an abortion may be performed. The Center for Reproductive Rights is challenging the Oklahoma and Florida laws; however, both are currently in effect.

While most states with enforced parental involvement laws make outright exceptions for medical emergencies, South Dakota and Idaho enacted laws during the 2005 session that require parental notification within twenty-four hours after the performance of an emergency abortion on a minor. In South Dakota this requirement can be avoided if a minor indicates that she will seek a judicial bypass, whereas in Idaho a physician must deem it in the minor's best interests to not report the abortion to a parent. Additionally, the new Idaho law requires the automatic appointment of a guardian ad litem for all minors seeking judicial bypasses. The ACLU and PPFA challenged the constitutionality of Idaho's judicial bypass and post-emergency reporting requirement, and a federal district court struck down the statute in its entirety. Idaho did not appeal the merits of the district court's holding that aspects of the judicial bypass and post-emergency reporting requirement are unconstitutional, but the State has appealed on severability grounds. The case is currently pending in the Ninth Circuit.

Kansas has adopted a measure that requires any physician who performs an abortion on a minor under the age of 14 to retain fetal tissue extracted during the procedure and send it to the Kansas Bureau of Investigation. The tissue is to be submitted "for the purpose of DNA testing and examination," and will allegedly be used to investigate incidents of child rape.

Finally, the Missouri Legislature convened a special session specifically to pass anti-abortion legislation. As a result, Missouri enacted a law that limits the definition of those qualified to accompany a minor to another state to obtain an abortion by excluding

from the “next friend” definition another minor or anyone with “financial interest or potential gain” in the impending abortion. PPFA has challenged this provision. A trial court upheld the statute after giving it a narrowing construction, and therefore dissolved the preliminary injunction. At the same time, though, the court issued an injunction pending appeal, so the statute has been found constitutional, but is still enjoined.

D. Targeted Regulation of Abortion Providers (TRAP)

TRAP laws regulate the medical practices of doctors who provide abortions by imposing burdensome requirements that are different and more stringent than regulations applied to comparable medical practices. These excessive and unnecessary government regulations ultimately harm women’s health and inhibit women’s reproductive choices by making abortions more expensive and increasingly difficult to obtain.

In the 2005 legislative session, approximately fifty-two TRAP bills were introduced in nineteen states. The majority of these bills sought to require abortions to be performed in hospitals, in ambulatory surgical centers, or by a physician with admitting privileges at a local hospital. Other bills would require abortion facilities to be licensed by the state’s health department. Also this session, we tracked several bills that would regulate abortions performed after the first trimester.

Of the fifty TRAP bills introduced in 2005, four were enacted (Florida, Indiana, Mississippi, and Missouri) and one was vetoed (Kansas). Florida enacted a bill that imposes regulations on abortion clinics where second-trimester abortions are performed. The TRAP regulations passed in Indiana mandate that all abortion clinics performing surgical abortions be licensed pursuant to regulations promulgated by the health department. The Missouri TRAP measure, adopted as a result of a special session includes a requirement that any physician who provides an abortion must have admitting privileges at a hospital within thirty miles of the location where the physician performs the procedure.

In Mississippi, a law was enacted to amend a Mississippi TRAP bill held unconstitutional by the Federal District Court. During the 2004 legislative session, the state of Mississippi enacted a law requiring all abortions performed after the first-trimester take place in a licensed hospital or ambulatory surgical facility (ASF). Notably, abortion facilities in Mississippi are ineligible to become licensed as ASFs or hospitals. The Center challenged this 2004 measure and the court found that the law was unconstitutional because it amounted to a ban on second-trimester abortions in the state. During the 2005 session, the Mississippi Legislature enacted another bill regulating abortions after the first-trimester. Unlike the 2004 law, however, the new provision states that, in addition to ASFs and hospitals, second-trimester abortions can be performed at a Level I abortion facility. Abortion providers appear to be eligible under this law to obtain a Level I license.

The Governor of Kansas vetoed a bill that would have required the promulgation of detailed regulations for abortion clinics. The governor explained that while she

supports updating regulatory oversight to ensure the best possible treatment for all patients in Kansas, the proposed legislation, “falls far short of meeting this basic standard of care.” The Kansas Legislature failed to override the governor’s veto of the bill.

E. Clinic Access

The anti-abortion movement has focused much of its energy on picketing abortion clinics and harassing women who seek reproductive health care. Laws promoting access to reproductive health generally establish “buffer zones” around abortion clinics to permit women to pass safely and without such harassment. This session, the Center tracked six bills in four states dealing with clinic access. Montana enacted a bill that protects the right to obtain medical treatment by establishing penalties for persons who obstruct access to health care facilities. Similar bills were introduced in Rhode Island and Utah, but did not see any movement. In Massachusetts a law was introduced that would repeal the state’s existing clinic access law.

F. Funding Crisis Pregnancy Centers

Currently eleven states allow motorists to purchase “Choose Life” license plates, which channel funds to non-profit, anti-abortion organizations, including so-called “crisis pregnancy centers” (agencies that promise comprehensive medical advice and pregnancy services but deliver anti-abortion propaganda instead). During the 2005 legislative session, we monitored thirteen license plate bills, introduced in nine states, of which one, in Ohio, was enacted. The new Ohio law permits motorists to pay an extra \$30 for a “Choose Life” license plate, with \$20 of the proceeds going toward non-profit groups that encourage adoption. This law is currently being challenged by the ACLU of Ohio, but is in effect and the license plates are available for purchase.

Moreover, this session, we saw the introduction of over twenty bills that would provide direct financial support to crisis pregnancy centers and other organizations that support abortion alternatives. Five of these bills were enacted in Kansas, North Dakota, Minnesota, Missouri, and Michigan. In Kansas, a bill was adopted that supplies competitive grants to not-for-profit organizations that provide services to encourage women to carry their pregnancies to term. The law prohibits grants to groups that provide abortion services. North Dakota created a program to promote childbirth over abortion. The law appropriates \$500,000 over two years, through the transfer of funds currently allotted to the Temporary Assistance for Needy Families (TANF) program, to be used to inform pregnant women about adoption and parenting. The “Positive Alternatives Act” was created this session by a Minnesota law that appropriates 5 million dollars over a four year period to encourage women to carry their pregnancies to term. Missouri enacted a law that designates more than one million dollars in federal and state funds for women “at or below 200 percent of the Federal Poverty Level” to be used to encourage women to carry their pregnancies to term, pay for adoption, or assist with caring for dependent children. Notably, the Missouri funds are only available during pregnancy and one year thereafter.

III. CONTRACEPTION

A. Emergency Contraception

Emergency contraception, commonly referred to as “EC” or the “morning-after pill,” refers to a high dose of ordinary prescription birth control pills that sharply reduces the likelihood of pregnancy if taken within three days of unprotected sex.

The dominant legislative model for providing wider access to EC is the “collaborative practice” bill, under which a licensed pharmacist can become authorized to dispense EC without a prescription by entering into a written agreement with a physician. This session, the Center tracked ten collaborative practice bills introduced in eight states, of which two, in New Hampshire and Massachusetts (through an override of the Governor’s veto), were enacted into law. A similar New York measure was passed by the legislature but vetoed by the Governor.

In Vermont and Oregon, collaborative practice bills passed one house of the legislatures. The Maryland Senate passed an EC access bill under which a pharmacist would not need to enter into a written agreement with a physician, but could instead complete a brief training course to become qualified to dispense EC. The bill failed to pass the Maryland House before the legislature adjourned.

Also this session, the Center tracked twenty-four bills introduced in fourteen states that would provide EC related information and services in hospital emergency rooms for survivors of sexual assault. Three of these bills reached the governor’s desk, resulting in a signed “EC in the ER” law in New Jersey and gubernatorial vetoes in Colorado and Massachusetts. Notably, the Massachusetts Legislature voted to override the governor’s veto, and the law was enacted without signature. An Arkansas EC in the ER bill passed one house before the Arkansas Legislature adjourned for the 2005 session.

B. Refusal Clauses

The term refusal clause, in the context of reproductive rights, relates both to provisions that allow health care providers to refuse to perform abortion-related services and to provisions that allow pharmacists and other authorized dispensers to refuse to fill prescriptions for contraceptives based on moral, ethical or religious beliefs. This session we monitored refusal clause bills introduced as stand-alone bills, with titles such as “Right of Conscience Act,” as well as bills embedded into other provisions governing the practice of medicine or pharmacy.

Numerous bills were also introduced this session that would allow pharmacists and other authorized dispensers to refuse to fill valid prescriptions for birth control pills, emergency contraception, and other contraceptives. In 2005, the Center tracked twenty-seven measures in eighteen states that would allow a pharmacist to refuse to dispense a valid prescription because of moral beliefs. California enacted such a law.

Legislators also introduced eleven bills in nine states that would provide a right of refusal to hospitals, physicians, nurses and other health care providers for abortion-related procedures. A bill that would provide refusal rights for both health care providers (related to abortion) and for pharmacists (related to contraceptives) passed one house in Ohio before the legislature adjourned.). The governors of Arizona and Wisconsin vetoed bills that would have had the same impact.

Although negative pharmacist refusal legislation dominated the 2005 session, seven states (California, Missouri, New Jersey, Nevada, Pennsylvania, Wisconsin, West Virginia), proposed affirmative legislation that would require pharmacies to fill prescriptions for contraceptives. California passed a measure that permits pharmacists to refuse to fill prescriptions if patients can still access their medication in a timely manner. Moreover, in Illinois, the governor issued an emergency regulation requiring all pharmacies that stock contraceptives to ensure that all prescriptions for contraception, including EC, are filled without delay.

C. Contraceptive Equity

The Center tracked twenty-two contraceptive equity bills introduced in thirteen states during the 2005 legislative season. Contraceptive equity laws generally require health insurance plans that provide prescription drug coverage to include contraceptive drugs and devices within that coverage. These laws redress the common discriminatory practice of insurance plans covering virtually all prescription drugs, including medication for erectile dysfunction, while declining coverage for contraceptives. This session, contraceptive equity laws were signed in both Arkansas and West Virginia, bringing the number of states with such laws to twenty-three. The Arkansas measure is a somewhat weak mandate, however, in that it specifically excludes emergency contraception from the coverage requirement. The New Jersey Legislature approved a bill of this kind, which now awaits the governor's signature. A contraceptive equity measure passed one house in Oregon before the close of the session.

IV. ELEVATING THE LEGAL STATUS OF THE FETUS

A. Fetal Homicide

This session was also marked by a significant number of bills that would elevate the legal status of the fetus. The Center tracked 119 fetal rights measures introduced in forty states, including bills that would establish the fetus as an independent victim of homicide or grant the fetus a right of "personhood" for the purpose of state laws or state constitutional guarantees.

Fetal homicide was a major focus of legislators this session, with six new laws enacted (Arizona, Florida, Illinois, Maryland, Oklahoma, and West Virginia). The Illinois law amends the definition of victim for violent crimes to include an unborn child. In Maryland, the governor signed a bill into law that recognizes a viable fetus as a distinct victim of murder, manslaughter, or unlawful homicide. Unlike the other fetal

homicide bills passed this session, however, the Maryland law explicitly states that the newly enacted measure should not be construed to confer personhood on the fetus. Laws enacted in West Virginia and Florida recognize pre-viable fetuses as independent victims of homicides (“embryo or fetus” and “unborn quick child”, respectively). While fetal homicide laws were passed in Oklahoma and Arizona that contain no viability requirement, and can be enforced for the unlawful killing of a fetus at the “moment of conception” or “at any stage of development.” All of the laws passed this session contain exceptions for legal abortion.

Fetal homicide bills in Kansas and Oregon that would have established a fetus “at any stage of its development” as a possible homicide victim passed one house of those legislatures before adjournment.

Also this session we tracked bills that elevate the severity of crime or the sentence a person can receive for killing a pregnant woman. Maine enacted two such laws, one which allows for an increased sentence for the homicide of a pregnant woman and the other of which creates a new crime of “elevated aggravated assault” on a pregnant woman. Bills that would assist the state in determining whether a homicide victim was pregnant by requiring the medical examiner to include pregnancy on the death certificate were introduced in seven states, and one was enacted in Colorado. A law was adopted in Virginia barring the execution of pregnant inmates.

B. Prenatal Use of Controlled Substances

This year we saw an increased number of bills that would allow civil intervention and, in some instances, criminal prosecution of women for using illegal substances during their pregnancies.

Five states (Arizona, Arkansas, Colorado, Louisiana, and Oklahoma) enacted legislation that expands the definition of “abuse” or “neglect” to include instances where drugs are present in the infant’s system at birth. Arkansas adopted a law that expands the definition of “neglect” under the Child Maltreatment Act to include prenatal drug use that causes a child to be born with an illegal substance in its system or a drug-related health problem. Colorado enacted a statute that expands the definition of “child abuse or neglect” to include instances in which an infant tests positive at birth for a controlled substance. Nevada amended its child abuse statutes to require health professionals and other specified persons to refer cases in which a newborn infant has been affected by prenatal drug use or exhibits withdrawal symptoms to child welfare services. Louisiana amended the Children’s Code to provide that “neglect” includes instances when a newborn is identified by a health care provider as having been affected by prenatal drug use or exhibiting symptoms of withdrawal.

In Arizona, a law was enacted that amends the Dangerous Crimes against Children Act in a manner that allows for addicted pregnant women to be prosecuted for child abuse and drug transfer to minors. Rather than directly amend the definition of “abuse” or “neglect” to include prenatal drug use, as in the four states above, Arizona

reached a similar result by amending the definition of “minor who is under twelve years of age” to include an unborn child.

Oklahoma also opened the door to possible prosecution of addicted pregnant women by enacting a fetal homicide statute that contains an unusually limited exception for conduct by the mother. While many of the fetal homicide statutes provide an exception for any conduct of the pregnant woman, Oklahoma’s new law provides that “under no circumstances shall the mother of the unborn child be prosecuted for causing the death of the unborn child unless the mother has committed a crime that caused the death of the unborn child.” Because drug use constitutes a crime, it is possible that a pregnant woman in Oklahoma could be prosecuted for fetal homicide if her prenatal drug use resulted in death of a fetus.

V. CONCLUSION

Additional information about what is happening in the states, including fact sheets, information about laws on the books, and updates about cases being brought by the Center can be found on our website at www.reproductiverights.org. Our website also contains a report entitled, “What if Roe Fell: The State-by-State Consequences of Overturning *Roe v. Wade*,” which provides a detailed study conducted by the Center analyzing the impact that a *Roe* reversal would have on each state. The Center will continue to track legislation for the 2006 legislative session.