2015 STATE OF THE STATES:

FIGHTING BACK BY PUSHING FORWARD

CENTER FOR REPRODUCTIVE RIGHTS

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INTRODUCTION

The headline-grabbing attacks on abortion access and reproductive rights occurring in Washington, DC, in the latter half of 2015—while outrageous in disregarding women's health for political gain and harmful in their contribution to an increased level of hostility facing abortion providers and growing stigma facing abortion patients—should not stand out as unusual. They are the continuation of years of extreme hostility in state legislatures in every region of our nation, and indicative of the well-coordinated, well-financed political network intent on dismantling our constitutional right to abortion by any means necessary.

2015 was no exception to this multi-year trend. We've seen legislators continue to enact the kinds of abortion restrictions that result in clinic closures and a crisis in access, while also expanding existing unjust abortion restrictions through extended mandatory delay policies and harsher restrictions for young people who need care. A new crop of outrageous bills made their debuts, signifying the ongoing experimental nature of measures introduced by opponents of safe, legal abortion care. Such opponents are less concerned with medical necessity, scientific accuracy, patient health, or constitutional rights than they are with scoring cheap political points. In 2015, many courts did their duty by applying the U.S. Constitution and U.S. Supreme Court precedent to expose abortion restrictions from years past as medically unjustified attacks on reproductive rights.

Increased awareness surrounding the cost and regulation of reproductive health care services, coupled with an unparalleled energy around the importance of sharing the stories of the estimated one in three women who will receive abortion care, is mounting momentum to reverse the trend in the states. This report outlines the very real and impactful attacks on abortion enacted this year while also highlighting the exciting successes of our movement, from policy progress to victories in the courts. The chipping away of reproductive rights has occurred at all levels of government, under the dome and in the courtroom. Our movement to restore our rights must also be multi-faceted. We can continue to move forward in achieving our vision of quality, comprehensive, and affordable reproductive health care access and information for everyone who needs it, no matter where she lives, her income level, or her health insurance status by capitalizing on our successes and learning lessons from the defeats.

STATE REPRODUCTIVE HEALTH RESTRICTIONS ENACTED IN 2015

In 2015, politicians once again tried to sneak around the Constitution to pass laws that shut down clinics and take away patients' access to affordable and safe reproductive health care. These extremist state lawmakers continued their assault on reproductive freedom, introducing almost 400 bills and enacting 47 new restrictions on access to reproductive health care. Many of these measures were Targeted Regulations of Abortion Providers (TRAP) laws, politically motivated restrictions that do not apply to any other similar health care, interfere with patient's personal decision-making, and ultimately block access to abortion care.

Disturbingly, states throughout the southern United States passed a plethora of restrictions to erect new barriers to block or delay women from receiving abortion care. It is particularly troubling that these restrictions were enacted in a region of the country where care is already scarcely available. For example, five southern states expanded the period of time that women must wait between receiving state-mandated biased counseling and obtaining an abortion. This medically unnecessary and harmful requirement forces each patient to make two separate trips to receive the care that she needs and demeans her ability to determine the best decision for herself and her family. Were it not for a court order blocking such a law in Florida, *every single southern state* would force patients to delay their care. Additionally, Texas, Tennessee, and Arkansas enacted new measures that make it all the more difficult for vulnerable communities—including young women and women living in rural areas—to access reproductive health services.

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Extremist politicians prioritized bills that interfere with the patient-provider relationship despite overwhelming consensus from medical experts that those bills are medically unnecessary and ultimately harmful. State legislatures enacted dangerous laws requiring medical providers to give biased counseling based in junk science. Sixteen organizations that oppose inappropriate political interference in the practice of medicine, including the American Congress of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the National Physicians Alliance, criticized such bills in Arizona and Arkansas because they "requir[e] health care professionals to violate their medical training and ethical obligation to their patients." These laws force doctors to

practice bad medicine. New measures were also enacted in Kansas and Oklahoma to criminalize doctors who provide safe abortion care with the most common and medically-proven method of ending a pregnancy in the second trimester. Such laws force patients to undergo an additional invasive procedure, intrude in the patient-provider relationship and attack women's health care and personal autonomy.

Despite years of U.S. Supreme Court precedent, politicians pursued bans on abortion at twenty weeks—unwarranted measures designed to roll back our rights and take away a woman's ability to determine the best decisions for herself and her family. Not only are these laws medically unwarranted and dangerous to women's health and well-being, they are also unconstitutional; the Supreme Court has blocked similar laws in each state where they have been challenged.

These are just some of the politically motivated trends in state measures passed in 2015; here is a state-by-state overview of restrictions on reproductive health care enacted this year.

ARIZONA

On the heels of losing two court battles defending unconstitutional attacks on abortion care in just the last two years, this year Arizona enacted SB 1318, which includes two new restrictions on access to abortion. First, the bill requires health care providers to inform patients that medication abortion may be "reversed." This statement is based on junk science and motivated by nothing more than the desire of anti-abortion extremists to control women's reproductive choices. By forcing health care providers to give patients unscientific, unsubstantiated information, this new requirement violates the First Amendment and is irresponsible medicine at its worst.

Second, SB 1318 amends the state's current ban on insurance coverage for abortion in plans offered in a state-run health care exchange. Existing law allowed insurers to offer optional riders that provided coverage for abortion for which the woman paid an additional premium. SB 1318 takes away that option, barring enrollees from purchasing riders that would allow them to afford abortion care. Under SB 1318, Arizona now withholds coverage from a woman who purchases insurance on a health care exchange in the state unless the abortion is necessary to preserve her life or avert a serious physical health risk, or for cases of rape or incest. Restrictions on insurance coverage for abortion like Arizona's not only interfere with a woman's ability to make personal decisions, but also disproportionately harm women who already face barriers to accessing health care, including low-income women and women of color.

In June, the Center for Reproductive Rights, along with the American Civil Liberties Union (ACLU) and Planned Parenthood Federation of America (PPFA), challenged the medication abortion "reversal" counseling requirement in SB 1318 in federal court. We argue that the law forces doctors to lie to their patients in violation of the First Amendment, and violates patients' constitutional right to choose abortion because it requires them to receive false, misleading, and irrelevant information prior to obtaining care. In June, the court temporarily blocked enforcement of the law while the case proceeds.

ARKANSAS

The Arkansas legislature unleashed an all-out assault on access to safe, legal abortion care in 2015, enacting the highest number of new anti-abortion laws by a state this year. The state passed:

- HB 1578, which requires physicians to provide false information based on junk science to their patients by forcing them to inform patients that medication abortion may be "reversed." This bill also doubles Arkansas' waiting period to 48 hours and forces all women to make two separate trips to a provider in order to obtain an abortion;
- HB 1076 and SB 53, two different laws banning providing medication abortion via telemedicine;
- HB 1394, a law requiring physicians to adhere to an outdated, less effective, and more expensive protocol for providing medication abortion;
- HB 1424, which creates more onerous requirements for teens who cannot involve their parents in their decision to have an abortion; and
- SB 569, which defunds Planned Parenthood.

This onslaught further burdens women seeking abortions, particularly low-income women, in what is the second-poorest state in the country and the second-worst state for women's and children's health and well-being.

FLORIDA

In 2015, Florida politicians enacted HB 633, a harmful measure that would force a woman seeking an abortion to wait at least 24 hours between listening to her physician recite state-mandated biased counseling and receiving care, necessitating that each woman make two separate trips to the clinic. The Center and the ACLU challenged the law in state court, arguing that it violates the strong privacy protections guaranteed by the Florida Constitution. On June 30th, a state court temporarily blocked the law while the case proceeds. Were it not for this order, every single Southern state would have a law in effect forcing a woman seeking an abortion to delay care, with some states forcing women to wait 48—or even 72—hours.

Waiting period requirements are medically unnecessary and demeaning, and have the potential to endanger a woman's health and well-being, even more so when, as in Florida, they require a second trip to a clinic. Such laws jeopardize the health of women seeking abortions, potentially preventing or delaying women from accessing reproductive health care and exposing them to risks associated with continuing a pregnancy or later abortion procedures. These restrictions can also endanger women who face the threat of abuse at home, making it twice as likely that a woman's abuser will learn of her plans. For many women, this requirement may be inconvenient, but for a woman working to make ends meet, the extra trip can be financially burdensome, potentially necessitating additional child care, hotel or transportation costs, and lost wages. And ultimately, this measure calls into question a woman's ability to determine for herself the best decision for her health.

IOWA

Iowa has a history of sneaking abortion restrictions into what for many states is the final bill of the year, and one that must pass—the budget bill. Iowa's budget included abortion restrictions yet again this year, with provisions in the bill that meddle in the informed consent process by mandating how doctors provide care. IA SB 505 requires doctors to offer to every woman, regardless of her individual circumstances or the doctor's best judgment, the opportunity to view an ultrasound image of the fetus. This law, which is similar to measures in other states that require abortion providers to either offer or force women to view images and hear descriptions of ultrasounds, is motivated by legislators' belief that women are incapable of making their own thoughtfully considered decisions about their health without intervention by the state.

IDAHO

This past session, Idaho enacted two bills (HB 154 and HB 189) prohibiting the use of telehealth services exclusively for medication abortion. Idaho enacted these restrictions despite the fact that for rural and low-income individuals, telemedicine has become a critical delivery method for many kinds of health care, such as psychiatric and primary care, enhancing the accessibility of quality care for people across the United States. In the context of medication abortion, a safe, effective way of ending a pregnancy in its earliest stages using medications, telemedicine enables a rural patient 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. The specific ban on providing medication abortion via telemedicine singles out abortion for unjust treatment to the detriment of the women who need it most.

Moreover, HB 154 includes TRAP provisions that have the capacity to restrict access to medication abortion altogether. Under the law, no physician may provide medication abortion unless he or she has admitting privileges at a local hospital, or a written transfer agreement with a physician that has such privileges. Idaho passed this law despite the fact that there is no documented medical reason to require these privileges, and despite the fact that abortion care is an incredibly safe procedure with a major complication rate below 1%. Physicians who provide more medically complicated care are not required to have these privileges. In other states, where physicians cannot get admitting privileges or cannot get a local doctor to agree to provide care (largely due to abortion stigma), physicians have to stop providing abortion altogether and clinics close. It remains to be seen whether this could happen in Idaho, but it is clear that Idaho lawmakers are passing restrictions on medication abortion for political and ideological reasons, and not in the name of women's safety.

INDIANA

Though abortion is already heavily regulated in Indiana, the state enacted two new laws this year that create more red tape for abortion providers to navigate. First, SB 329 singles out abortion providers by requiring them to either incinerate or bury medical waste resulting from abortions, which could make abortion prohibitively expensive or more difficult to obtain in the state.

Second, SB 546 increases reporting and recordkeeping requirements imposed on abortion providers, subjecting them to administrative requirements more burdensome than those applicable to comparable health care providers. However, SB 546 eases some requirements in current law imposed on facilities that only provide medication abortion. A 2013 law had required facilities where only medication abortion is provided to comply with the same onerous physical plant requirements and other standards that apply to facilities that provide surgical abortion. That law also prohibited the state health department from issuing waivers to clinics exempting them from these unnecessary physical plant requirements even when patient safety was not threatened. This rule unfairly singled out abortion providers, as other comparable medical facilities are eligible for waivers under state law if the exemption would not adversely affect patient health, safety, or welfare. As amended by SB 546, abortion facilities are treated the same as other licensed health care facilities with respect to seeking waivers from construction requirements and other excessive regulations.

The ultimate goal of these politicians is to criminalize women's health services one by one until no safe, legal options are available to any woman who makes the decision to end a pregnancy.

KANSAS

Taking a page directly from the National Right to Life playbook, Kansas enacted SB 95 with the intention of banning the safest and most commonly used method of ending a pregnancy in the second trimester. The law could have forced providers to perform an additional, unnecessary procedure instead of providing a second trimester abortion under the already safe and effective standard of care. The Center challenged the law in state court, arguing that it violates Kansas women's constitutional rights, including the rights to bodily integrity and to abortion. The law is currently blocked by the court as the case proceeds.

This attack on abortion care is part of a coordinated effort by anti-abortion Kansas legislators to make it extremely difficult to obtain abortion at any stage of pregnancy. Access to early abortion care is severely restricted in Kansas, forcing some women to delay care—only to be banned from accessing abortion altogether because of laws like SB 95. The ultimate goal of these politicians is to criminalize women's health services one by one until no safe, legal options are available to any woman who makes the decision to end a pregnancy.

In June, a state court judge temporarily blocked the law from taking effect as the case proceeds. The Center for Reproductive Rights challenged the law on behalf of one of only three abortion providers in the state. The Kansas Court of Appeals, sitting en banc, will hear oral arguments in December.

MONTANA

This year, anti-choice lawmakers in Montana launched a new wave of attacks on access to essential reproductive health care services in the state, including safe and legal abortion care. A trilogy of vetoes from Gov. Steve Bullock proved to be the only thing standing between anti-choice forces in the legislature and the women of Montana.

First, anti-choice politicians passed HB 587, a ban on the use of telemedicine for abortion care, including medication abortion. The bill, which would have violated the strong protections provided by the Montana Constitution, could have disproportionately harmed low-income and rural women. In a state where approximately 44 percent of the population live in rural areas and where 46 percent of women live in a county without an abortion provider, telemedicine represents an innovative approach to improving abortion access for rural women, and research shows that providing medication abortion through telemedicine is safe and effective.

Once HB 587 arrived on Gov. Steve Bullock's desk, he saw the legislation for what it truly was: a callous attack on Montana's most vulnerable women. The governor vetoed the bill, stating that "Montana's elected officials have no business substituting their personal beliefs for the sound medical judgment of our health care professionals or the deeply personal medical decisions of their constituents."

The legislature passed two additional anti-abortion measures: SB 349, which would have required insurance companies to provide plans without coverage for comprehensive reproductive health care, and HB 479, a medically unfounded "fetal pain" measure. Gov. Bullock vetoed both of these bills, rejecting them as further attempts "to substitute the legislature's beliefs" for the sound medical judgment of Montana's health care professionals and the private medical decisions of patients.

NORTH CAROLINA

This year, North Carolina joined the short list of states with the longest waiting period in the country when the legislature passed a law requiring abortion patients to wait 72 hours between receiving state-mandated counseling and obtaining the abortion. By extending their existing 24-hour waiting period an extra two days, the state is clearly sending a message that it does not believe women are capable of making their own decisions and is punishing women for making decisions the state does not agree with.

North Carolina also joined the bandwagon of states attempting to defund abortion providers who also provide family planning—namely, Planned Parenthood. This year, North Carolina's budget bill (HB 97) forbids states from funding family planning, pregnancy prevention, or adolescent parenting contracts with any organization that also performs abortions. These cruel cuts will restrict access to critical preventive care for those in need all in the name of anti-abortion politics.

OKLAHOMA

Despite the fact that the Center has taken Oklahoma to court six times between 2010 and 2014 to stop unconstitutional restrictions on abortion and contraception, the legislature tripled down on its laser focus on abortion this session, enacting three new laws that restrict access to this critical reproductive health service.

It's time for Oklahoma politicians to prioritize truly advancing women's health and safety—Oklahoma women should not have had to go to court eight times in five years to protect their basic constitutional rights and access to critical health care.

First, HB 1721 criminalizes physicians who provide services to women seeking safe and legal abortion care by banning the safest, most effective, and most commonly used method of ending a pregnancy in the second trimester. This law could force some women to undergo an additional, invasive, unnecessary medical procedure, even against the judgment of her physician. Oklahoma is the second state, after Kansas, to enact this dangerous and unconstitutional legislation.

Second, HB 1409 triples the state's existing state-mandated waiting period, joining only four other states in the nation to force abortion patients to wait at least 72 hours before they can receive care. A 72-hour waiting period serves no purpose other than to shame women seeking safe, legal abortion care and second-guess a woman's ability to decide for herself what is right for her and her family.

Third, SB 642 is a kitchen sink anti-abortion measure that enacts a hodgepodge of new restrictions on abortion patients and providers based on the policy recommendations of the anti-abortion advocacy group Americans United for Life. Among other provisions, this law could be interpreted to authorize law enforcement to bring felony charges for a minor violation of the more than 140 laws targeting physicians and clinics that provide abortion care. The state might claim, for instance, that SB 642 permits prosecution of a clinic employee or physician for posting a state-mandated sign in a font different from that dictated by statute. Another provision of the law permits warrantless searches of facilities that provide abortion. This law is a flagrant violation of settled state law that expressly forbids the legislature from addressing multiple subjects in one piece of legislation.

The Center challenged all three of these laws in two separate actions in state court, arguing that they violate the Oklahoma Constitution. State court judges have temporarily blocked both HB 1721 and SB 642 as cases proceed. However, the court failed to issue an injunction on the state's punishing 72-hour waiting period, forcing Oklahoma women to delay constitutionally protected health care for at least three days. It's time for Oklahoma politicians

to prioritize truly advancing women's health and safety—Oklahoma women should not have had to go to court eight times in five years to protect their basic constitutional rights and access to critical health care.

RHODE ISLAND

Restrictions on insurance coverage for abortion are one of the oldest strategies in the book for anti-choice policymakers and continue to proliferate in states across the country, blocking women from care they have a legal right to but cannot access. Rhode Island attempted to prohibit coverage of abortion care in private insurance plans in the 1980's; however, those restrictions have been permanently enjoined as unconstitutional for as many years. Current law also withholds insurance coverage for abortion in plans offered to public employees and low-income residents except in the cases of life endangerment, rape, and incest.

While Rhode Island does not prohibit plans in the state exchange from providing abortion coverage, this year the state passed HB 5900, which requires at least one health plan at each tier in the exchange to exclude coverage for abortion services. In addition, the measure requires employees of religious employers that refuse to offer plans that cover abortion to pay for abortion coverage themselves.

SOUTH DAKOTA

Year after year, South Dakota legislators enact restrictions on access to abortion care, and 2015 was no different. South Dakota already has the most extreme waiting period law in the nation, requiring abortion patients wait at least 72 hours between receiving state-mandated counseling and obtaining care, not including holidays or weekends. To add insult to injury, HB 1130, enacted this year, prohibits an abortion provider from accepting payment for any services rendered prior to a woman completing this waiting period—a prohibition that applies only to abortion providers and not to any other type of health care provider. HB 1130 represents yet another effort from anti-choice politicians in the state to single out abortion providers for discriminatory treatment and further stigmatize abortion patients.

TENNESSEE

After the passage of a ballot amendment stripping state constitutional protections for abortion in Tennessee, the legislature immediately introduced a dozen bills restricting access to abortion, two of which passed into law less than six months after the amendment took effect. First, SB 1280 is a clinic shutdown law that requires clinics performing more than 50 surgical abortion procedures per year to meet the same building requirements as a hospital-like ambulatory surgical treatment center, threatening to close two clinics in the state. Second, SB 1222 requires people seeking an abortion to endure state-mandated, biased counseling and then make a second trip to the provider 48 hours later to receive care. Mandatory waiting periods present numerous difficulties and barriers to patients, including increased costs of travel, time off work, and childcare logistics, among other issues. Some providers reported significantly reducing health care appointment times to accommodate the extra in-person counseling sessions for women traveling from both within Tennessee and outside of the state.

The Center challenged both laws in federal court, and the court blocked the state from imposing criminal penalties against clinics that do not meet the new hospital-like standards under SB 1280 as litigation is ongoing.

TEXAS

Just two years after the Texas legislature enacted HB 2, an omnibus anti-abortion law that leaves all but ten clinics in the state at risk of closure, politicians in the state continue to chip away at abortion access. This session, Texas enacted two new laws restricting access to critical reproductive health care services.

First, Texas enacted yet another omnibus measure, HB 3994, this time explicitly targeting minors, undocumented women, and low-income women. HB 3994 contains a multitude of restrictions designed to make it as challenging as possible for the most vulnerable communities to access abortion care. For example, it requires all adult patients to provide "proof of identity and age" verifying they are not a minor. The law requires a patient without such proof to attempt to obtain it, which could delay critical and time-sensitive care. This "abortion ID" requirement could serve as a backdoor ban on undocumented women and low-income women from obtaining abortion care.

The bill also decimates abortion access for abused and neglected Texas teens. The U.S. Supreme Court has long held that the U.S. Constitution permits states to require a minor to involve a parent before obtaining an abortion, so long as the state also provides an alternative

The Trust. Access. Respect. campaign rallied Texans to the capitol in support of access to essential reproductive health care. (Photo credit: NARAL Pro-Choice Texas)

means by which she can seek authorization. This alternative usually takes the form of a judicial bypass procedure, a court proceeding in which the minor asks a court's permission to obtain an abortion without involving her parents. The Court has held time and time again that this hearing must be confidential, expeditious, and provide the teen with an "effective opportunity" to obtain the desired abortion.

HB 3994 upends the state's current law governing teens who seek court approval in order to obtain abortion care. For example, one provision could amount to an arbitrary veto on a minor's ability to obtain an abortion by providing no recourse if a court fails to rule within the statutorily prescribed time. Another provision will also endanger the confidentiality of minors seeking a bypass by limiting the venue in which they can file a petition for most teens to their county of residence—which could threaten the privacy of teens in rural and tight-knit communities. And HB 3994 likely violates the constitutional requirement of expeditiousness by extending the time for the lower and appellate courts to rule to five business days each, potentially delaying a decision for weeks or more.

Second, Texas enacted HB 416, a targeted regulation of abortion providers that requires staff at abortion facilities—and no other regulated health care facilities—to complete a state-mandated training program that helps workers identify victims of human trafficking. While ensuring prompt services are available to human trafficking victims may be a laudable policy goal, there is no reason to single out *only* abortion facilities to complete this type of training. Indeed, anti-

ATTACKS ON PLANNED PARENTHOOD

This summer, extremist anti-abortion activists waged a smear campaign against Planned Parenthood, attempting to depict its staff as breaking a federal law that prohibits the sale of fetal tissue. In reality, no laws were broken, and the fact remains that fetal tissue donation is a compassionate decision made by some abortion patients to contribute to advancements in research and treatment for medical conditions like Parkinson's and Alzheimer's. Rather than discredit Planned Parenthood and the care its health care providers offer to millions of Americans, the campaign only exposed the real agenda of anti-abortion extremists, which is to ban abortion and cut women off from reproductive health care altogether using dishonest and potentially illegal tactics.

In the wake of the release of these misleading and heavily edited videos, state policymakers sprung to action, eager at the opportunity to score political points at the expense of women's health. Though many states were out of session, anti-abortion politicians introduced over 20 bills in response to the deceptive videos, ranging from legislation that would ban fetal tissue donation altogether to bills that would greatly increase the cost of abortion care by dictating how providers must dispose of medical waste resulting from abortions. In addition, state officials opened more than a dozen investigations into Planned Parenthood, and at least a dozen states attempted to cut off access to critical preventive care provided by Planned Parenthood by defunding or ending state contracts with Planned Parenthood health centers. To date, not a single state investigation has revealed any wrongdoing on Planned Parenthood's part. The Center for Reproductive Rights stands with Planned Parenthood and calls on politicians to abandon this misguided effort to disparage the quality, compassionate care provided at their health centers.

abortion politicians' true motive to further restrict and stigmatize abortion providers became clear when they rejected an amendment to broaden the bill's reach to include other types of health care providers who may provide care to human trafficking victims. If Texas lawmakers are truly concerned about the plight of victims of human trafficking, they should ensure that *all* health care providers have appropriate training to identify them, not just abortion providers.

WEST VIRGINIA

Following Gov. Earl Ray Tomblin's veto of an identical bill in 2014, this year the West Virginia Legislature passed the nation's 15th law banning abortions after 20 weeks of pregnancy, HB 2568. Citing concerns about constitutionality, Gov. Tomblin sided with West Virginia women and families once again by vetoing the legislation. Unfortunately this year, the legislature overrode the governor's veto and enacted HB 2568 into law. The bill provides no exceptions for rape or incest survivors and only an extremely narrow exception for medical emergencies and lethal fetal anomalies. The very few West Virginia women who may need to seek abortion services after 20 weeks already face extreme barriers to care, as there are only two clinics providing abortion services in the entire state. Laws like HB 2568 are unconstitutional, unconscionable, and unwarranted, and legislators should focus on advancing real measures to protect women's health and well-being, not dangerous political measures that deny women access to critical care.

Wisconsin policy advocates partnered with medical professionals to push back on politically-motivated attacks on abortion care. (Image credit: Wisconsin Alliance for Women's Health)

WISCONSIN

In recent years, the Wisconsin legislature has attacked abortion access from multiple fronts, banning insurance coverage for the procedure, restricting access to medication abortion, and enacting a clinic shutdown law that Wisconsin providers have been fighting since 2013. Not content with making it more challenging for women to access earlier care, this year the legislature passed SB 179, the nation's 16th law banning abortions after 20 weeks, with an extremely narrow exception for medical emergencies. Wisconsin politicians ignored opposition from major medical groups in the state in pushing this legislation, including the Wisconsin Section of the American Congress of Obstetricians and Gynecologists, the Wisconsin Medical Society, and the Wisconsin Academy of Family Physicians, as well as objections from a group of 100 obstetrician-gynecologists.

Ohio lawmakers and advocates collaborated to introduce an agenda of proactive policies to advance reproductive health and rights. (Photo credit: NARAL Pro-Choice Ohio)

BRIGHT SPOTS IN THE 2015 STATE LANDSCAPE

While we face a very real abortion access crisis in the states, discussing the abortion restrictions enacted this year only tells part of the story. 2015 was a watershed year for proactive reproductive health and rights policy, with nearly 300 measures introduced in state legislatures across the country intended to protect or advance reproductive health and rights. There were some great successes following this unprecedented number of introductions, especially the enactment of laws expanding access to contraception and protecting pregnant workers from discrimination. Advocates and lawmakers also worked together to move crucial measures to stop politicians from intruding in the patient-provider relationship, protect women from employer discrimination based on their reproductive health decisions, and restore coverage for abortion care.

State coalitions took important steps to articulate their proactive vision by introducing packages of bills to advance reproductive health, rights, and justice. Policy agendas introduced in Pennsylvania, Washington, Texas, and Ohio promote trust in a patient's ability to make the decisions that are best for her health, push back against political interference in the patient-provider relationship, and protect clinicians providing essential reproductive health services. For example, the Pennsylvania Campaign for Women's Health worked primarily with the bipartisan Women's Health Caucus to reintroduce an agenda of 13 bills that safeguard the patient-provider relationship, institute workplace protections and accommodations for pregnant workers, and increase the minimum wage. To push back against the onslaught of restrictions in Texas, policy leaders launched Trust. Respect. Access. The campaign is building momentum around policies that trust Texans to determine the best health care decisions for themselves, respect medical professionals to provide high-quality medically accurate health care, and provide patients with access to a full range of essential reproductive health care.

ENSURING QUALITY AND ACCURATE HEALTH CARE

It is essential that the patient-provider relationship is based on mutual trust and a commitment to medical accuracy and evidence; despite this, many state abortion restrictions directly conflict with this tenet. That's why three states introduced the Patient Trust Act in 2015 to restore the centrality of the patient-provider relationship. These bills would ensure that the state cannot require a health care professional to provide medically inaccurate or inappropriate information to a patient, or to provide care in a manner that is not evidence-based.

Although the measures introduced this year in Arizona (HB 2635), Pennsylvania (HB 1105), and Texas (HB 708 / SB 1395) have not yet passed, they sent a strong message that doctors should not be forced to lie to their patients in order to follow the law or discard the most recent medical evidence when providing care.

A strong coalition of advocates lobbied in the capitol for a bill requiring all insurance providers to cover a broad range of reproductive health services. (Photo credit: Western States Center)

States also took action to ensure women are receiving medically accurate and unbiased care by curtailing the harms caused by crisis pregnancy centers (CPCs). CPCs are typically institutions run by anti-choice organizations or churches that adopt a pseudo-medical façade but don't actually employ qualified health care practitioners or provide a full range of information and services. Many CPCs intentionally mislead patients considering abortion, and often provide women with inaccurate or patently false information about abortion and contraception. This year, the California legislature stepped in to educate patients about the manipulation and misinformation of these groups by passing the Reproductive Freedom, Accountability, Comprehensive Care, and Transparency (FACT) Act (AB 775), signed by Gov. Jerry Brown in October. The FACT Act requires CPCs to inform women if they are not medically licensed or do not have a licensed medical provider on staff. Further, it requires facilities in the state that provide services related to pregnancy to inform clients about their reproductive rights in California and about state programs that are available to provide financial assistance for accessing reproductive health care. Relatedly, Ohio legislators introduced HB 376, which would require CPCs funded through the state government to only provide medically accurate information.

THE STRONG FAMLIES RESOLUTION

The "Strong Families Resolution" (HR 746) calls for comprehensive reproductive health care for all Georgians. Introduced in 2015, this proactive resolution identifies racial disparities in reproductive health care access and outcomes, and advocates for strong policies that address health equity, including family needs in both the home and workplace. For example, the resolution cites the need for action due to Georgia's shortage of health care providers, lack of widespread access to prenatal care, and disproportionately higher rates of negative health outcomes experienced by African American women than white women. The resolution also highlights that the well-being of women and their families depends on a dynamic and inclusive range of proactive policies, such as those that address racial disparities in pregnancy complications, encourage workplaces supportive of working families, and facilitate high-quality childcare. Furthermore, the resolution calls for increased access to a range of essential health care services, including annual check-ups, timely pre- and postnatal care, and safe abortion care. The resolution, championed by the Thriving Families Georgia Coalition, will cross over into the 2016 legislative for further consideration.

IMPROVING INSURANCE COVERAGE FOR REPRODUCTIVE HEALTH SERVICES

Several bills to address discrete reproductive health care needs related to the provision of health insurance or services were enacted in 2015.

In Illinois, legislators enacted a law establishing the Illinois Sexual Assault Emergency Treatment Program Fund (HB 3848). This law prohibits a hospital and a variety of health care professionals from directly billing a sexual assault survivor for medication related to her treatment. Lawmakers in the state also enacted HB 2812 in order to protect patient confidentiality for those covered by Medicaid Managed Care Entities. This law preserves the privacy of those seeking health care services that a patient may wish to remain confidential, such as mental health, reproductive health, substance abuse, and domestic abuse services, by ensuring details about that care are not included in the Explanation of Benefits (EOBs) to the insurance policy holder. EOBs are considered important for purposes of transparency and fraud protection; however, for people aged 25 and younger who receive health coverage through a parent's plan, or for people who receive health coverage through someone else such as a spouse, this new law allows for more overall patient privacy.

Similarly, Oregon legislators enacted a bill to address patient confidentiality in 2015. HB 2758 prohibits an insurance carrier or third party administrator from disclosing to anyone other than the enrollee receiving services protected health information regarding services

like abortion care and family planning. Additionally, Oregon enacted HB 3343 to improve a woman's ability to access a full years' prescription for contraception. There is no medical reason a woman must only receive a monthly supply of her contraceptive prescription; in fact, there is evidence that allowing for a full year's supply of contraception to be dispensed—and covered by insurance—at one visit to the pharmacy helps reduce the unintended pregnancy rate.

Advocates and lawmakers tapped into the energy of the All* Above All movement to take steps toward restoring public insurance coverage for abortion care. Legislation that lifts bans on abortion coverage is designed to ensure that each woman has access to the health care she needs, regardless of her income level or her insurance provider. In Oregon, a coalition of advocates led a campaign to advance SB 894, a bill that would require all insurance providers to cover a broad range of reproductive health services, including abortion, a full year of birth control (which passed in a separate bill), pre- and post- natal care, and breastfeeding assistance. State advocates built a community-focused strategy, including the release of the We Are BRAVE Toolkit by the Western States Center and a lobby day, led by NARAL Pro-Choice Oregon. Washington advocates introduced the Reproductive Health Act (SB 5574), requiring that all health plans that cover maternity care include abortion care. In Illinois, lawmakers introduced HB 4013 to repeal decades-old state law that bans coverage for abortion care in the medical assistance program and for state employees. In Ohio, legislators introduced HB 356 and HB 360 to help restore insurance coverage for abortion in both public and private insurance markets. These bills could help increase access to abortion whether a woman has insurance through the state marketplace, state Medicaid, or as a state employee.

EXPANDING CONTRACEPTIVE ACCESS BY BROADENING THE SCOPE OF PRACTICE

It is essential that a woman have access to contraception in order to determine for herself whether and when to have a child. However, if a woman's preferred birth control method is difficult to secure, she may not be able to follow the requirements of her method. As a result, states are taking steps to broaden access to birth control through expanded duties for medical professionals. Following unanimous approval from both chambers of the legislature, Illinois Gov. Rauner signed HB 421, which broadens the authority of advanced practice nurses (APNs) to provide prescriptions for certain medications, including oral contraception and emergency contraception. This amendment to the Nurse Practice Act allows APNs to perform certain duties, including writing some prescriptions, without requiring them to have a written collaborative agreement with physicians—expanding access to contraception for people in Illinois. Oregon passed HB 2879, which allows pharmacists to provide contraceptive pills and hormonal patches without a prescription after a woman self-administers a risk-screening test.

FIGHTING EMPLOYER DISCRIMINATION

No woman should be discriminated against by her employer because she wants to access the contraception that works best for her. This year, six states introduced the "boss bill," a

measure that would prohibit employers from imposing their religious beliefs on their employees by discriminating against them for their reproductive health decisions, such as using contraception or in vitro fertilization. In New York, AB 1142 passed the state assembly, but the bill stalled in the state senate. Connecticut (HB 6159), Maine (HB 698), Michigan (HB 4715 / SB 397), Missouri (HB 354), and Washington (HB 1502) also considered such measures.

INCREASED PROTECTION FROM DISCRIMINATION FOR PREGNANT WORKERS

A growing number of states have passed laws that would increase protections for pregnant workers, 15 of which explicitly grant the right to reasonable accommodations in the workplace. This year, 16 states introduced 22 such measures, and four were enacted in Rhode Island, Nebraska (LB 627), North Dakota (HB 1463), and New York (SB 8). For instance, Rhode Island's SB 276 requires employers to provide leave or reasonable accommodations for employees experiencing limitations on their ability to work due to pregnancy or childbirth, and ensures employees receive written notice of their rights.

In addition, Florida enacted SB 982, which adds pregnancy to the state's Civil Rights Act, making discrimination on the basis of pregnancy unlawful. The law prohibits discrimination against pregnant people in a number of arenas, including employment, public lodging, and food services establishments.

DEFENDING THE RIGHTS OF PREGNANT INCARCERATED PEOPLE

Women who are incarcerated often face mistreatment when they are pregnant, in labor or delivery, and post-partum. In fact, the United States is one of the few countries that uses restraints on pregnant incarcerated women. Nearly half of states have now passed laws prohibiting the use of shackles during at least some part of pregnancy, labor, and delivery, but more policy strengthening and attention to implementation are necessary to ensure women's human rights are being upheld. For example, a study of New York state prison practices found that in spite of a state law prohibiting shackling pregnant inmates during labor, prison authorities continue to do so. As a result, the New York legislature passed AB 6430 to remove the remaining limited shackling provisions in the state. The bill awaits Governor Cuomo's signature. Additionally, the Minnesota legislature amended its existing anti-shackling bill to include provisions regarding standards of care during pregnancy and to add new reporting requirements (SB 878 / HB 849).

STATE POLICY & ADVOCACY RESOURCES

In 2015, the Center produced a number of new resources to educate the public and support the work of state legislators and advocates across the country, both in defending against restrictive bills and in advancing a proactive vision. We share these and other resources via a quarterly proactive policy newsletter, Building Power. Please email Julie Bero at jbero@reprorights.org to subscribe.

The Center collaborated with more than 60 organizations in the reproductive health, rights, and justice movements to create a proactive policy compendium, *Moving in a New Direction: A Proactive State Policy Resource for Promoting Reproductive Health, Rights, and Justice*. Designed as a resource and jumping off point for advocates and legislators alike, the compendium identifies key areas of need including family planning services, pregnant women's rights, and meaningful access to abortion. It highlights the proactive policies that have been introduced in the states in recent years to address them.

Instead of working to improve women's health, in 2015, West Virginia and Wisconsin joined the growing list of states with bans on abortion at 20 weeks, with the U.S. Congress and state legislatures in Michigan, Ohio, and South Carolina considering similar bans. As part of our multifaceted efforts to put a stop to these sham laws that only purport to promote women's health, the Center released *Bans on Abortion at 20 Weeks: Unconstitutional, Unconscionable, and Unwarranted*, a guide to help state and federal reproductive health and rights advocates address the problem.

Nuestro Texas, the groundbreaking human rights campaign led by the Center and the National Latina Institute for Reproductive Health (NLIRH), released a proactive policy blueprint in February 2015, prior to the 84th Texas legislative session: *Nuestro Texas: A Reproductive Justice Agenda for Latinas* and a post-session analysis.

In March, the first-ever domestic women's human rights hearing was held in the Rio Grande Valley of Texas to raise awareness of the human rights violations taking place in the region. The event was hosted by the Center, NLIRH, U.S. Human Rights Network, and ten Texas-based organizations that also worked together to release ¡Somos Poderosas!, a report on the hearing that includes new data about the dire lack of health care access in the region and testimony from many of the affected women.

In 2016, the Center for Reproductive Rights looks forward to collaborating with our partners across the country to fight back against political attacks on our constitutionally-protected rights and to strengthen our movement for accessible, affordable, and high-quality reproductive health care. For more information on state legislative activity or to collaborate on state policy and advocacy work during the 2016 sessions, please contact Kelly Baden at kbaden@reprorights.org.

WHEN HARMFUL LEGISLATION PASSES: THE ROLE OF THE COURTS IN 2015

Given the legislative landscape of the past few years, reproductive health providers have needed to turn to courts to block many harmful laws. As noted above, courts have already preliminarily blocked some of the laws passed in 2015 (while litigation is ongoing). This year also saw many important final court decisions protecting women's access to abortion services, as state and federal courts blocked unconstitutional and harmful state laws. A notable exception was the Court of Appeals for the Fifth Circuit, which upheld parts of a Texas law that would deny huge numbers of Texas women safe access to abortion where they live, even while it blocked a similar law in Mississippi on constitutional grounds. The 5th Circuit's misguided and inconsistent approach set up a U.S. Supreme Court challenge that the Center is currently litigating, with a landmark ruling for abortion rights expected in June 2016. The Supreme Court case and other key decisions from 2015 are highlighted below.

THE SUPREME COURT CONSIDERS TRAP LAWS

As TRAP (targeted regulations of abortion providers) laws continue to proliferate in the states, state and federal courts have played a major role by repeatedly stepping in and blocking them from taking effect. State legislators enact TRAP laws to purportedly protect women's health, but these claims are false. Evidence shows that TRAP laws harm women's health, in part by forcing high-quality physicians and long-established clinics with stellar safety records to stop providing abortion services.

Given the dubious health and safety justifications for these restrictions and the harms they create, courts have largely blocked recently enacted TRAP laws. Courts rely on settled U.S. Supreme Court precedent which requires that when a state seeks to limit women's ability to exercise their constitutional right to abortion services in the interest of promoting women's health, courts must meaningfully scrutinize whether the restrictions actually serve that interest. In a recent decision in the challenge to a Texas law, however, the Court of Appeals for the Fifth Circuit did not follow that precedent (as discussed below), so the Center has asked the Supreme Court to step in.

TEXAS: THE FIFTH CIRCUIT GETS IT WRONG

In 2013, the Texas Legislature enacted HB 2, despite diligent efforts by reproductive health advocates and the filibuster led by State Sen. Wendy Davis that helped spark a series of protests in support of reproductive rights in Texas and beyond. HB 2 includes requirements that abortion providers obtain admitting privileges at a local hospital and that each health care facility offering abortion services meet the same building specifications as ambulatory surgical centers. Together, these requirements would

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The Center—representing Whole Woman's Health and several other Texas health care providers—filed a federal lawsuit challenging these parts of the law. At trial, multiple experts testified that these requirements do not make abortion—an extremely safe procedure—any safer. Based on the evidence, the trial court found that, contrary to Texas's claims, the requirements will not improve health or safety, but actually would expose women to greater health risks by drastically reducing the number and geographic distribution of licensed abortion providers in the state, and concluded they are unconstitutional because they impose an undue burden on women's access to abortion. However, in a June 2015 decision, the Fifth Circuit largely upheld the requirements on appeal, ruling that courts may not examine whether evidence supports a state's claim that a law restricting abortion access protects women's health. That decision has not taken effect, because the U.S. Supreme Court agreed to block it while the legal challenge continues.

In September 2015, the Center for Reproductive Rights asked the U.S. Supreme Court to review the case, and permanently correct the Fifth Circuit's failure to apply the Constitution and legal precedent. In November 2015 the Court granted the Center's petition for review, with the Texas case headed for oral arguments in early 2016 and a decision likely in June.

The Center is asking the Court to affirm its 1992 holding in *Planned Parenthood v. Casey* that legislatures cannot pass "[u]nnecessary health regulations" that have the "purpose or effect of presenting a substantial obstacle to a woman seeking an abortion. . . ." The case provides the Court with an excellent opportunity to make it clear that the right to reproductive health care access must be a right in reality, not just in theory, and that courts have a vital responsibility to consider whether abortion restrictions purportedly meant to protect women's health actually do so, to protect against states using that as a pretext for shutting down clinics.

To learn more about Whole Woman's Health v. Cole, the crucial legal challenge to protect abortion access in Texas, visit protectabortionaccess.org.

Fortunately, not all of the judges on the Court of Appeals for the Fifth Circuit have erred in their legal rulings. Also in 2015, Mississippi officials asked the Court to review another TRAP decision – a 2014 ruling by different judges on the Fifth Circuit in the Center's challenge to a Mississippi law that would require all doctors associated with an abortion facility to have admitting privileges at a local hospital. The appellate court upheld the preliminary ruling blocking that requirement from going into effect, thus enabling the one remaining abortion clinic in Mississippi to stay open. The Texas and Mississippi rulings are inconsistent, calling for the Supreme Court to set the 5th Circuit straight. As of November 2015 the Supreme Court had taken no action on Mississippi's petition for review, presumably intending to resolve the inconsistency with its June 2016 decision in the Texas case.

LOWER COURTS BLOCK TRAP LAWS

The Fifth Circuit's approach in Texas is truly renegade. While the Supreme Court has not yet spoken on the latest wave of TRAP laws, the cases below show that in 2015, other courts played a vital role in protecting women's access to abortion services. These courts did their duty by applying the U.S. Constitution and Supreme Court precedent to expose such restrictions as medically unjustified attacks on women's rights.

Alabama: *West Alabama Women's Center v. Williamson* (Federal District Court, August 2015)

In *West Alabama Women's Center*, an abortion clinic and doctor challenged an Alabama regulation requiring doctors who provide abortions to have admitting privileges at a local hospital or contract with a doctor who has privileges. After the clinic's doctor retired, hospitals and doctors in the area refused to accommodate his successor and the clinic was forced to close; the ACLU then filed suit. While the state insisted that the purpose of the law was to protect women's health, the court found "the evidence suggests that the regulation's justification of protecting women's health as applied to this clinic is weak," given that the clinic had an impeccable safety record, as did the doctor it sought to employ. In addition, the court found that the obstacles that the regulation placed before the clinic and Alabama women seeking to exercise the constitutional right to abortion "loom large." Balancing the lack of health and safety benefits against the burdens for women—who would need to travel lengthy distances, brave unfamiliar cities, and pay higher transportation costs, if they could reach another clinic at all—the court ruled that the requirement should be blocked and unenforceable while the court challenge continues.

Louisiana: *June Medical Services v. Kliebert* (Federal District Court, May 2015)

Abortion providers, represented by the Center, challenged a 2014 Louisiana law requiring doctors to have admitting privileges at a local hospital, claiming that the law was unconstitutional burden on abortion access and that the medical unreasonableness of the admitting privileges requirement should be considered by the court in evaluating the law's constitutionality. The state officials sought to prevent introduction of evidence at trial about the medical unreasonableness. In a May 2015 decision, the trial court ruled that evidence

of the lack of medical justification for the requirement was relevant to the claim that it is unconstitutional. It then held a trial, in June 2015, in which it considered this evidence. The court has not yet issued its decision.

Wisconsin: *Planned Parenthood of WI v. Schimel* (formerly *Van Hollen*) (Federal District Court, March 2015; Federal Court of Appeals, Seventh Circuit, November 2015)

Schimel started as a challenge to a 2013 Wisconsin law requiring doctors to have admitting privileges at a local hospital, in a case brought by the ACLU and Planned Parenthood. After expressly examining the state's health justification and finding that the law offered negligible health benefits, while imposing substantial obstacles to women seeking abortion services, the federal trial court issued its post-trial decision in March 2015, permanently blocking the law as unconstitutional. The court found that "the marginal benefit to women's health of requiring hospital admitting privileges, if any, is substantially outweighed by the burden this requirement will have on women's health outcomes due to restricted access to abortions in Wisconsin." By examining the state's health claim, the court properly exposed the state's true purpose—to restrict abortion and place an undue burden on women. The opinion relied on a prior decision in the case, in which the Court of Appeals for the Seventh Circuit upheld the trial court's preliminary injunction and directed the district court to scrutinize the state's health claims, not accept them at face value, at trial. Wisconsin, refusing to recognize a lost cause, appealed the permanent injunction to the 7th Circuit, which again found the law to be unconstitutional and completely devoid of a legitimate medical purpose.

As these cases show, most courts in 2015 did the right thing when reviewing TRAP laws that legislatures tried to justify with false health and safety claims. The reasoning applied by these courts is in sharp contrast to the reasoning used by the Court of Appeals for the Fifth Circuit in the Texas TRAP case. It now falls to the Supreme Court to correct the Fifth Circuit's mangling of settled law.

COURTS BLOCK PRE-VIABILITY BANS

As some courts addressed the onslaught of TRAP laws in 2015, other courts held the line against unconstitutional pre-viability bans on abortion. U.S. Supreme Court precedent is clear on this point: both *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992), the two foundational abortion rights cases, explicitly prohibit bans on abortions prior to fetal viability as violations of women's constitutional right to liberty. Every court that has reviewed a pre-viability ban—whether at 6, 12, or 20 weeks—has struck it down as a clear and indisputable violation of constitutional law. The following cases show that even judges who express hostility to abortion recognize this bright-line rule.

Arkansas: *Edwards v. Beck* (Federal Court of Appeals, Eighth Circuit, May 2015)

In May 2015, the Court of Appeals for the Eighth Circuit permanently blocked an Arkansas state law that prohibited abortion at 12 weeks of pregnancy, in a case brought

by the Center and the ACLU. In a unanimous decision, the three-judge panel stated that the bright-line Supreme Court rule prohibiting pre-viability bans forced it to hold the law unconstitutional. The court refused to accept Arkansas' claim that the law was not an actual ban:

While the opinion also showed open hostility to abortion rights and encouraged the Supreme Court to revise its support for abortion access before viability—a troubling invitation—the judges could not deny that current case law absolutely prohibits denying women access to abortion. In October 2015 the state of Arkansas asked the Supreme Court to review the decision.

"The State tries to frame the law as a regulation, not a ban, on pre-viability abortions because they are available during the first 12 weeks (and thereafter if within the exceptions). Whether or not 'exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.' [quoting Planned Parenthood v. Casey]. By banning abortions after 12 weeks' gestation, the Act prohibits women from making the ultimate decision to terminate a pregnancy at a point before viability."

Idaho: *McCormack v. Herzog* (Federal Court of Appeals, Ninth Circuit, May 2015)

In May, the Ninth Circuit Court of Appeals affirmed the trial judge's decision striking down an Idaho law that prohibited abortion after 20 weeks. The challenge was brought on behalf of a woman who was criminally charged for self-inducing a medication abortion, joined by a doctor who planned to provide such abortions. The appellate court held that the U.S. Constitution and U.S. Supreme Court precedent clearly prohibit pre-viability bans on abortion, stating: "The broader effect of the statute is a categorical ban on all abortions between twenty weeks gestational age and viability. This is directly contrary to the Court's central holding in Casey that a woman has the right to 'choose to have an abortion before viability and to obtain it without undue interference from the State.'"

North Dakota: *MKB Management v. Burdick* (Federal Court of Appeals, Eighth Circuit, July 2015)

The same Eighth Circuit judges who permanently blocked Arkansas' pre-viability ban in May did the same in July in the Center's challenge to North Dakota's pre-viability ban. The North Dakota statute prohibits abortion after a fetus has a detectable heartbeat, which can be as early as the sixth week of pregnancy. The court noted that Supreme Court precedent clearly and indisputably prohibits bans on abortion, with or without life and health exceptions for the mother, before a fetus can survive outside the womb. Although the three-judge panel (including judges who are openly opposed to abortion) expressed dissatisfaction with the Supreme Court's rule, it also noted that the law on this point is clear: "Because there is no genuine dispute that [the law] generally prohibits abortions before viability… and because we are bound by the Supreme Court precedent holding that states may not prohibit pre-viability abortions, we must affirm the district court's grant of summary judgment to the [abortion providers]." In November 2015, North Dakota asked the Supreme Court to review the decision.

In sum, there is simply no legal dispute that pre-viability bans on abortion violate U.S. Supreme Court precedent. Even judges who express the view that the Supreme Court should retract its long-standing protection for women's rights acknowledge this fact. In 2015, those judges fulfilled their duty to stop pre-viability bans in their tracks.

COURTS PROTECT AGAINST OTHER HARMFUL ABORTION RESTRICTIONS

In addition to considering TRAP laws and abortion bans, courts in 2015 issued decisions blocking other types of abortion restrictions as well.

Medicaid Restrictions – Unconstitutional

Alaska: *Planned Parenthood of the Great Northwest v. Streur* (Alaska Supreme Court, September 2015)

An Alaska law and regulation that eliminated Medicaid funding for most abortions apart from some narrowly defined exceptions was challenged by the Center, the ACLU, and Planned Parenthood. Previously, the Alaska Supreme Court had ruled, based on the

state constitution, that medically necessary abortions must be covered using state Medicaid funds, just as other medically necessary care must be covered by Medicaid. The legislature sought to narrow that earlier ruling. In September, based on a full trial record, a state trial court found the new law violated the equal protection clause in Alaska's constitution because it imposed restrictions on public funding for medically necessary abortions, but not on other health care procedures. The court carefully discussed the terrible consequences this would have for poor women who rely on Medicaid, while discounting testimony from the state's anti-abortion medical experts who relied on "personal moral standards" instead of science.

Telemedicine Restrictions - Unconstitutional

Iowa: *Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine* (Supreme Court of Iowa, June 2015)

The Iowa law at issue prohibited off-site doctors from using telemedicine to speak to patients and prescribe pills for medication abortion, even when trained staff at a clinic had physically examined a patient and completed all exams and tests for the doctor to review. The law, challenged by Planned Parenthood, did not comply with the standard of care developed by the American College of Obstetricians and Gynecologists, nor with Iowa's standards for telemedicine use in other medical procedures. The Iowa Supreme Court explicitly examined the state's claim that the law advanced women's health, holding: "Consistent with United States Supreme Court precedent, we must now weigh the health benefits of [the rules] against the burdens they impose on a woman who wishes to terminate a pregnancy. As the foregoing indicates, the record evidence showed very limited health benefits." Because the law was medically unnecessary and severely restricted women's access, the court struck it down as an undue burden.

2015: MAJOR DEVELOPMENTS IN ABORTION RIGHTS LITIGATION

Planned Parenthood of the Great Northwest v. Streur: The Alaska Superior Court struck down a state law and regulation that would have severely limited Medicaid coverage of abortions for low-income women, holding that the funding scheme violated the equal protection guarantees of the Alaska Constitution.

West Alabama Women's Center v. Williamson: A federal court blocked Alabama from enforcing a law against an abortion clinic whose only provider could not secure local hospital admitting privileges or a backup arrangement with a physician who has such privileges required by state law, despite the physician's experience and safety record. The clinic reopened while the case continues.

Edwards v. Beck: The U.S. Court of Appeals for the Eighth Circuit affirmed a lower court decision striking Arkansas' blatantly unconstitutional ban on abortions after 12 weeks of pregnancy. In October, Arkansas asked the U.S. Supreme Court to overturn the lower court's ruling.

Planned Parenthood of the Heartland v. Iowa Board of Medicine: The highest court in Iowa ruled that the state's ban on providing medication abortion using telemedicine violated the state constitution.

McCormack v. Herzog: The U.S. Court of Appeals for the Ninth Circuit affirmed a lower court's ruling that Idaho's ban on abortion at 20 weeks violated settled constitutional law prohibiting states from banning abortion prior to viability.

June Medical Services v. Kliebert (formerly June Medical Services v. Caldwell): A federal court challenge to a Louisiana clinic shutdown law. A trial on a preliminary injunction was held in June 2015, with a decision expected in late 2015. The law is temporarily blocked.

Jackson Women's Health Organization v. Currier: The U.S. Supreme Court took no action on a petition filed by the state of Mississippi asking it to uphold a 2012 Mississippi law that threatens to close the only abortion clinic in the state. The law is currently blocked by the 5th Circuit.

MKB Management Corporation v. Burdick: The U.S. Court of Appeals for the Eighth Circuit affirmed a lower court decision striking North Dakota's blatantly unconstitutional ban on abortions after six weeks of pregnancy. In November, the state of North Dakota asked the Supreme Court to overturn the lower court's ruling.

Capital Care v. Ohio Department of Health: An Ohio state court ruled that a burdensome requirement that abortion providers have a transfer agreement with a local hospital was unconstitutional as applied to an abortion provider that had its licensed revoked because its transfer agreement was with a hospital in the neighboring state of Michigan.

Whole Woman's Health v. Cole: The U.S. Supreme Court agreed to review two restrictions in the anti-abortion omnibus legislation enacted by Texas in 2013 that could reduce the number of abortion providers in the state to 10 or fewer.

Planned Parenthood v. Schimel: A federal court permanently blocked a Wisconsin clinic shutdown law that requires abortion providers to obtain admitting privileges at a local hospital. The state of Wisconsin appealed to the 7th Circuit, which affirmed the lower court's decision in November 2015.