

2016 State of the States:

***A PIVOTAL  
TIME FOR  
REPRODUCTIVE  
RIGHTS***

CENTER  
FOR  
REPRODUCTIVE  
RIGHTS



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# 2016 SAW INCREDIBLE VICTORIES FOR ABORTION RIGHTS.

**On June 27**, the Supreme Court delivered a huge victory to reproductive rights advocates in *Whole Woman's Health v. Hellerstedt*. The decision dealt a blow to sham abortion restrictions that purport to protect women's health and safety, striking down two laws that were part of HB 2, an omnibus abortion bill Texas enacted in 2013. The Court struck down as unconstitutional a requirement that abortion providers have admitting privileges at a local hospital, and a requirement that first-trimester abortion facilities meet the same hospital-like building standards as an ambulatory surgical center.

Both of these abortion restrictions—along with scores of similarly medically unjustified, red tape regulations—have been ubiquitous in state legislatures across the country since 2011. Since then, the Center has tracked more than 2,100 bills state legislators introduced that would restrict access to reproductive health-care. More than 300 of those have become law. The Supreme Court's decision in *Whole Woman's Health* does not erase these hundreds of restrictions from the books; rather, it sets forth a concrete, robust legal standard that litigators and advocates alike can use to block laws in the courts and stop them from becoming law in the first place.

But despite these victories, we face serious threats to women's reproductive rights—now more than ever before. The reality is that abortion access is still deeply restricted for many women. It will take years, if not decades, to undo the damage that has been done to abortion clinics and to evidence-based policymaking in recent years. In Texas alone, 20 clinics closed

after parts of HB 2 took effect; many of those may never open again. And for women\* who have been harmed by any number of unjustified abortion restrictions—a forced 72-hour waiting period, a ban on her insurance covering her care, to name a few—those dignitary harms cannot be undone. Reproductive rights advocates must use *Whole Woman's Health* to dismantle each and every sham abortion restriction on the books to ensure that every woman gets high-quality reproductive health-care without interference from politicians—and that won't happen overnight.

The Supreme Court issued the *Whole Woman's Health* decision *after* the vast majority of the more 60 bills restricting access to reproductive health-care were enacted in states across the country this year. In the first six months of 2016, anti-abortion advocates continued their smear campaign against Planned Parenthood in the wake of the deceptively edited videos released in 2015, attempting to depict its staff breaking a federal law that prohibits the sale of fetal tissue. Though no laws were broken, this year anti-abortion politicians doubled down on their agenda to discredit and defund Planned Parenthood.

Indeed, this year brought scores of legislation in response to the smear campaign: the Center tracked nearly 100 bills related to the sting alone. Eight states passed new laws intended to defund Planned Parenthood, and eight states passed laws that ban the donation of embryonic or fetal tissue or otherwise restrict the disposition of such tissue. And four states passed copycat legislation banning the standard D&E abortion procedure, the most



common method of terminating a pregnancy in the second trimester. These trends lay bare the true motives of anti-abortion advocates: to stigmatize women who need abortions and the providers who care for them. Undoubtedly, this new barrage of attacks shows that the anti-abortion movement has abandoned its pretense of protecting women's health and safety, instead making it crystal-clear that the end goal is attacking family planning providers and banning abortion care altogether.


Make no mistake—women's health advocates across the country are pushing back, and will continue to push back, against this extreme agenda. And given signals from the president-elect and new administration, we know that we must renew our commitment to defend the rights of women to make decisions that affect their health, their lives, their families, and their futures. The Center tracked nearly 300 bills this year that would expand or improve access to reproductive health-care services. These bills envision a world where a woman has access to the full spectrum of quality, affordable reproductive health-care so she can determine whether and when to have children and parent with dignity. States focused this year in particular on expanding access to contraception, such as legislation that allows a pharmacist to dispense 12 months of birth control at a time. All told, nearly every state considered pro-contraception legislation, and bills expanding access to contraception became law in eight states. And state policymakers moved to improve maternal health in a variety of ways, including establishing maternal mortality review boards, ensuring academic success for pregnant and parenting students, and strengthening legal protections for pregnant workers.

This report provides a state-by-state summary of new legislation enacted in 2016 that restricts access to reproductive health-care, the proactive strategies state policymakers are advancing that will strengthen access to family planning and abortion services, and an overview of the major litigation developments in 2016 related to reproductive rights. 2017 will undoubtedly bring new challenges and new opportunities for action. In congress, in the courts, and in our states, the pro-choice majority of our country must be heard.


*\*ALTHOUGH THIS REPORT USES FEMALE PRONOUNS AS WELL AS THE TERM "WOMAN," WE RECOGNIZE THAT PEOPLE WHO DO NOT IDENTIFY AS WOMEN STILL NEED ACCESS TO THE FULL RANGE OF REPRODUCTIVE HEALTH-CARE, INCLUDING ACCESS TO ABORTION CARE AND CONTRACEPTION. THE CENTER FOR REPRODUCTIVE RIGHTS INTENDS ALL POLICY RECOMMENDATIONS MADE IN THIS DOCUMENT TO APPLY TO ALL PEOPLE WHO NEED ACCESS TO REPRODUCTIVE HEALTH-CARE.*



# RESTRICTIONS ON REPRODUCTIVE RIGHTS ENACTED IN 2016


Fortunately, not every law that passed this year took effect. Please see the litigation section for information on which laws were blocked by courts in 2016 using  symbol.

## ALABAMA

Alabama legislators enacted two harmful anti-abortion laws that aim to shut down clinics and restrict providers' ability to deliver safe, legal abortion care. One, SB 363, effectively bans the safest and most commonly used method of ending a pregnancy in the second trimester, with extremely narrow exceptions. This law criminalizes physicians who provide safe abortion care and intrudes on the patient-provider relationship. Additionally, it could force patients to undergo an additional invasive procedure and represents a blatant attack on women's health-care and personal autonomy .

A second law, SB 205, prohibits the state health department from issuing or renewing a license to any abortion clinic located within 2,000 feet of a public school. This restriction is designed to close two specific clinics in the state and is nothing more than the latest attempt by anti-abortion politicians to block access to abortion under the guise of protecting public welfare. These laws were both challenged in federal court; neither is in effect.

## ARIZONA

Arizona passed a slew of new reproductive health restrictions, depriving women of access to the full range of reproductive options, including family planning. HB 2599 imposes complicated and vague conditions on abortion providers who also provide family planning, similar to a law Arizona passed in 2012. The ACLU and Planned Parenthood sued to block this copycat law from taking effect, arguing that it illegally dictates which Medicaid providers women can choose for family planning services . In keeping with politicians' focus on stripping funding of any kind from abortion providers, SB 1485 dictates where charitable deductions may be sent. The bill prohibits providing a payroll salary deduction to a charity that performs abortions or maintains or operates a facility that does. With this bill, Arizona is essentially seeking to eliminate all donations related to abortion. SB 1474 bans embryonic and fetal tissue from abortions for use in research except in narrow circumstances, and simultaneously threatens patient privacy by stating that investigations under this law are not subject to doctor-patient confidentiality. Arizona women who wish to donate embryonic or fetal tissue after an abortion are prohibited from doing so by this bill, stripping away their agency in medical decision-making.

Finally, Arizona also attempted to double down on medication abortion restrictions, but later repealed those restrictions in the same legislative session . For more on this turn of events, see the litigation section.

## FLORIDA

Florida legislators enacted HB 1411 – a harmful omnibus anti-abortion law that places additional restrictions and onerous requirements on abortion providers, jeopardizing their ability to provide reproductive health-care services. HB 1411 requires that all physicians performing first-trimester abortions to have either a transfer agreement with or admitting privileges at a nearby hospital. This is despite that fact that abortions are incredibly safe procedures with a major complication rate below 1%.



This law also mandates a host of reporting and inspection requirements that subject providers and patients alike to burdensome and invasive red tape in connection with abortion care, including making *half* of recent patient medical records available for state inspectors. Because comparable health-care providers are subject to less intrusive and onerous inspections, it's clear that this bill is about some politicians' desire to make abortion care impossible to provide, not about improving health-care for Floridians.

Detrimentially, this law also forbids providing public funding to any clinic licensed to perform abortions. This not only reduces the clinics' ability to offer abortion care; it also restricts access to critical preventative care that these same clinics may provide 🚫. The burdens of this defunding law are certain to fall the hardest on low-income communities. On top of this host of restrictions, HB 1411 includes a ban on fetal tissue donation, furthering the stigmatization of abortion care and those who receive it. This bill represents an extreme overstep on Florida's part in attacking women's access to safe, high-quality reproductive health-care.

## GEORGIA

Georgia law requires parental consent before a minor may terminate her pregnancy. However, as required by the U.S. Constitution, minors may obtain a judicial bypass if they are able to convince the judge to waive the requirement. HB 555 places several tracking requirements on the bypass procedure under Georgia law. Under the bill, court clerks are responsible for data collection, including the number of bypasses granted and the number of appeals to bypass denials. Though tracking bypasses sounds innocuous, it is possible Georgia will use this information to further restrict minors' access to abortion.

Georgia also enacted SB 308, which establishes a grant program for 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. Though many states allocate funding to CPCs in their budgets, some CPCs place conditions on the aid they give to women who do decide to carry to term, such as required Bible study classes. SB 308 therefore gives money to non-medical organizations in Georgia that often deliberately deceive women seeking abortion services and prevent them from obtaining care, and yet fail to freely give aid to women who do carry to term.

## IDAHO

Idaho enacted two bills that create onerous requirements for both abortion patients and providers. Existing Idaho law already required a woman seeking an abortion to wait at least 24 hours between listening to her physician recite state-mandated biased counseling and receiving care. HB 516 now requires providers, as part of this counseling, to inform patients that they may view and hear an ultrasound prior to an abortion and to direct them to a list of free ultrasound providers, regardless of whether or not patients have expressed a desire for this.

These requirements are medically unnecessary and demeaning. Mandating how doctors provide care, regardless of the patient's individual circumstances or the doctor's best judgment, meddles in the informed consent process and singles out abortion providers for discriminatory treatment. And with the requirement that doctors give patients a list of free ultrasound providers, the state is tacitly encouraging women to visit crisis pregnancy centers (CPCs), which have a long history of misleading women into thinking they are credible health-care providers and persuading women not to have abortions based on junk science. To add insult to injury, HB 516 also prohibits an abortion provider from accepting payment for any services rendered prior to a woman receiving this ultrasound information—a prohibition that applies only to abortion providers and not to any other type of health-care provider. Ultimately, this law is motivated by some politicians' belief that women are not capable of making their own thoughtfully considered decisions about their health without intervention by the state and serves to further stigmatize abortion providers.

In response to last year's Planned Parenthood sting operation led by anti-abortion extremists, Idaho legislators enacted SB 1404, banning the donation of fetal tissue resulting from an abortion. This law also mandates that providers speak with patients about their ability to determine a final disposition for fetal tissue. Although tissue donation is a compassionate decision made by some abortion patients to contribute to advancements in research, SB 1404 attempts to score political points at the expense of women's dignity.

## INDIANA


Indiana passed an omnibus bill that contains a number of harmful abortion restrictions. Under current state law, women must receive state-mandated counseling at least 18 hours prior to the performance of the abortion, but this counseling can take place via phone. Current law also requires that women undergo an ultrasound, but allows providers to perform the ultrasound at the same visit as the abortion. HB 1337 requires that women undergo the ultrasound 18 hours prior to the abortion procedure, together with the pre-abortion counseling. This medically unnecessary and harmful requirement means a woman will have to make two potentially lengthy and costly trips to exercise her right to access an abortion.

In addition, HB 1337 bans abortions that are sought solely due to the race or sex of the fetus, or solely due to the diagnosis or potential diagnosis of a genetic anomaly. Women are capable decision-makers, and this bill does not trust them to make the best decisions for themselves and for their families. Additionally, these reason-based abortion bans are wolves in sheep's clothing: though they may look like measures designed to combat discrimination, they are often the opposite.

Sex-based bans are rooted in insidious stereotypes about Asian and Asian-American women—that they prefer sons to daughters, and thus seek abortions based on the sex of the child. Anti-abortion politicians promote race-based bans based on harmful claims that comparatively higher rates of abortion in the Black community prove that Black women terminate pregnancies due to internalized racial bias. Disability-based abortion bans do nothing but politicize the lives of people with disabilities. Rather than pass proactive laws that




truly promote the health and well-being of people with disabilities, such as legislation that funds respite care and specialized education programs, Indiana politicians decided to insert ideology into the private lives of families. What’s more, years of Supreme Court precedent have established that it is unconstitutional to ban abortion prior to viability. HB 1337 contains unconstitutional pre-viability abortion bans that are part of the larger anti-abortion agenda to ban safe abortion care altogether under the guise of caring about the rights of women, people of color, and people with disabilities.

As if this weren’t enough, among other requirements, HB 1337 also mandates that embryonic and fetal tissue must be cremated or buried. Just as people would expect, there are already laws requiring safe and respectful disposal of embryonic and fetal tissue. This bill’s intended effect is to shame and stigmatize patients who choose abortion care, and to close clinics who serve those patients. Fortunately, a win in court by the ACLU and Planned Parenthood blocked all of the restrictions above from taking effect .

## KANSAS


The Kansas legislature enacted two new restrictions on access to reproductive health-care. Kansas HB 2615 bans midwives from performing abortion care—an unnecessary new law because Kansas already prohibits non-physician clinicians from performing abortions.

In addition, Kansas politicians continued their attacks on Planned Parenthood both inside and outside of the legislative process. SB 248 restricts state family planning funds to government-run programs in an effort to defund Planned Parenthood facilities that provide comprehensive reproductive health-care in the state. This bill was enacted on the heels of a state agency’s decision to terminate a Medicaid provider agreement with Planned Parenthood—an action that was subsequently blocked  by a federal court.

## KENTUCKY

State law in Kentucky already forces women to wait 24 hours between receiving state-mandated counseling and obtaining abortion care. Kentucky SB 4 now requires that the state-mandated counseling take place either in person in the physician’s office or via “real-time visual telehealth services.” If a woman lacks access to a computer or phone equipped for telehealth counseling, this law will require her to make two trips to the clinic in order to receive care—a requirement that will fall the hardest on low-income women.

## LOUISIANA

Louisiana took unprecedented aim at abortion rights this year, passing seven different bills restricting access to abortion—the highest number of any state in 2016. The Center challenged  each of these restrictions before they took effect. While the state agreed not to enforce each law while litigation proceeds, that may be cold comfort for the women of Louisiana when politicians prioritized attacking their constitutional rights and decision-making over the real problems facing them, including poverty, maternal health, and child welfare.

### The bills include the following abortion restrictions:

- HB 386 triples Louisiana’s current state-mandated waiting period from 24 hours to 72 hours. The bill provides an exception for women who live 150 miles or more from the nearest abortion clinic.
- HB 1081 bans the most common method of providing a second-trimester abortion, jeopardizing women’s health and interfering in the doctor-patient relationship.
- HB 488 adds even more red tape to the laws governing physicians who provide abortions in the state, requiring that they hold board certification in obstetrics and gynecology or family medicine or be enrolled in a residency program in one of those two specialties.
- HB 606 not only prohibits any state or local government agency from entering into any funding agreement with any abortion provider, but also prohibits state or local government officials from contracting with any third party that contracts with an abortion provider—further stigmatizing abortion care.
- HB 815 could effectively ban medication abortion in the state by imposing impossible requirements on patients and their physicians when the patient completes her medication abortion outside of a doctor’s office. The bill also requires fetal tissue that results from an abortion to be buried or cremated and bans the donation of fetal tissue.
- HB 1019 polices a woman’s reason for ending a pregnancy by banning abortion in cases of genetic abnormalities after 20 weeks.
- SB 33 imposes a prison term of hard labor for a minimum of 10 years on a person who receives reimbursement for expenses related to donating fetal tissue for medical research following an abortion. The measure does not impose the same criminal sanctions for tissue donation that results from a miscarriage.

## MICHIGAN


HB 4787 prohibits coercing another person to obtain an abortion. This bill is unnecessary because the informed consent process—required for *all* medical procedures—guarantees that patients are not experiencing outside pressure to make their decision. These anti-coercion laws may seem good on paper, but they are rooted in false assumptions that abortion patients have not made up their minds. In fact, recent research from Advancing New Standards in Reproductive Health ([www.ANSIRH.org](http://www.ANSIRH.org)) debunks the notion that the decision to have an abortion is surrounded by uncertainty and finds that women seeking abortion are at least as certain, if not more so, about their decision as people making other health-care decisions.








## MISSISSIPPI

Mississippi passed two new restrictions on access to reproductive health-care in 2016. HB 519 bans the most common method of providing a second trimester abortion—an unconscionable political interference into the doctor-patient relationship. The legislature also attacked Planned Parenthood and other reproductive health facilities by passing SB 2238, which prohibits granting public funds to any entity that performs abortions or is affiliated with an abortion provider .

## OHIO

HB 294 denies state grants to abortion providers that also provide family planning. However, this bill goes further than targeting abortion providers alone. HB 294 also denies state funding to any entity that contracts with a facility that performs or refers for abortion. Planned Parenthood was successful in blocking this bill from taking effect . In December, SB 127, which would ban abortions after 20 weeks, and HB 493, which would ban abortions as early as 6 weeks, were both approved and sent to Governor Kasich.

## OKLAHOMA

HB 2797 is an omnibus bill that creates the “Humanity of the Unborn Child Act.” This unprecedented piece of legislation requires the state Department of Health to develop and distribute materials “for the purpose of achieving an abortion-free society.” The bill also requires the development of anti-choice curricula that schools can use to indoctrinate students. Further, the bill requires the creation of stigmatizing signage for public restrooms that urge pregnant women to carry to term. Finally, the bill forbids state employees and programs from referring for abortion, with no exceptions.

Oklahoma also passed a total ban on abortion—with no exceptions—that was perhaps the most extreme anti-abortion bill to come out of a state legislature in the last ten years. However, Oklahoma’s Governor vetoed the bill, sparing the state a costly lawsuit where the law would have been struck down as blatantly unconstitutional.

## SOUTH CAROLINA

South Carolina legislators orchestrated a medically unjustified attack on reproductive freedom, enacting two bills that heavily restrict access to abortion care. First, SB 1035 prohibits the use of telehealth services exclusively for medication abortion, unless later approved by the state board of medicine. Medication abortion is a safe, effective way of terminating a pregnancy in its earliest stages, and provides a resourceful approach to improving abortion access in a state where 93% of counties have no abortion clinic. Telemedicine allows women to be examined at a local health-care center, and then speak with a physician working remotely who can review her medical history, discuss her options, and provide the necessary medication. Adding this onerous restriction on its use not only limits women’s reproductive health-care options, but it also demeans providers and undermines their medical expertise.

Second, legislators passed an unconstitutional ban on abortion after 20 weeks. This law, HB 3114, lacks basic protections for women’s health, allowing abortions after 20 weeks in very narrow circumstances. HB 3114 takes away a woman’s ability to determine the best decisions for herself and for her family and represents an unabashed agenda to roll back constitutional rights.

## SOUTH DAKOTA

South Dakota passed several laws that show that politicians in the state don’t trust women seeking abortions or the clinics that provide them. HB 1123 singles out abortion providers for different treatment from other healthcare facilities by requiring the health department to publicly post the result of each health inspection conducted of abortion providers—and not other licensed facilities. SB 24 bans fetal tissue donation, depriving women of the choice to contribute their fetal tissue for research.

SB 72 bans abortion after 20 weeks post-fertilization with narrow exceptions. Laws like SB 72 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.

Finally, SB 1157 requires health-care providers to inform patients that it is possible to “discontinue” a medication abortion by not taking misoprostol, the second pill taken in the protocol for medication abortion. 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 be a mouthpiece of the state by giving patients unscientific, unsubstantiated information, this new requirement violates the First Amendment and is irresponsible, intrusive policymaking at its worst.

## TENNESSEE

SB 2568 creates new, burdensome recordkeeping and reporting requirements for physicians who perform abortion care. The bill also creates a new requirement that the patient approve of the disposition of the embryo or fetus in some instances and adds new inspection requirements for abortion facilities.

## TEXAS FETAL TISSUE REGULATIONS

The ink was barely dry on the Supreme Court’s landmark decision in *Whole Woman’s Health v. Hellerstedt*, striking down two onerous and medically unjustified abortion restrictions Texas enacted in 2013, when policymakers in the state were at it again. Just four days after the Court’s decision, the state health department quietly proposed rules that would require health-care providers to bury or cremate the embryonic and fetal tissue that results from an abortion or miscarriage. This requirement would apply regardless of the woman’s personal beliefs or religious views. These rules, finalized in December, are brazenly politically-motivated and clearly designed not only to close clinics but to stigmatize abortion patients.

## UTAH

Utah enacted SB 234, a first-of-its-kind law that requires an abortion provider to use fetal anesthesia for abortion performed after 20 weeks, with very narrow exceptions. Existing Utah law already required physicians who perform abortions after 20 weeks to administer such anesthesia, so long as the woman consented to the procedure. Utah politicians *removed* that consent clause, laying bare the state’s true motive to strip abortion patients of their dignity and autonomy. SB 234 was purportedly enacted to protect fetuses from feeling pain at 20 weeks, despite the fact that rigorous scientific reviews of the evidence on fetal pain published by leading medical journals concluded that fetal perception of pain is unlikely before the third trimester.

## WISCONSIN

Wisconsin passed two separate bills related to funding of abortion providers, AB 310 and SB 238. AB 310 creates a tiered funding structure for family planning dollars. This type of funding structure causes a mandatory bias for which types of entities can get state money, ensuring that the bulk of state dollars go to state-run health facilities rather than other institutions, such as Planned Parenthood or other private reproductive healthcare facilities. Then, the bill prohibits sub-granting by a public entity to any organization that provides abortion or has an affiliate that provides abortion. This bill thus cuts out abortion clinics that also provide family planning in two ways. First, they’re last on the list to be able to receive funding. Next, they are prohibited from receiving money from a public entity that might be higher on the list. This type of funding prohibition, pioneered by Texas and resulting in massive health-care crises in the Rio Grande Valley, is gaining steam as a way to disenfranchise abortion providers who also provide family planning.

SB 238 is a new type of funding prohibition that attempts to reduce the amount of money providers can receive for services that qualify for Medicaid. This means that even if a facility is able to get family planning dollars, the fees they will receive from the government are lower than the fees for other types of health-care providers – even though they are both providing the same family planning service, such as birth control. Both of these types of funding restrictions explicitly target abortion providers and prevent some providers from being able to offer family planning services.

## WEST VIRGINIA

SB 10 bans the most common and medically proven method of ending a pregnancy in the second trimester. These laws force patients to undergo an additional invasive procedure, intrude on the patient-provider relationship, and attack women’s health-care and personal autonomy. Though the West Virginia Governor vetoed this bill, citing constitutional concerns, the West Virginia legislature overrode that veto and this law is currently in effect.

# DOCUMENTING THE IMPACT OF ABORTION RESTRICTIONS

Women’s health and safety are topics best defined by scientific research, not by state legislators’ agendas. Social science, public health, and medical research have played a major role in clarifying that definition over the course of the last year as it pertains to abortion care. Research briefs submitted to the United States Supreme Court in *Whole Woman’s Health v. Hellerstedt* provided extensive evidence that the restrictions in Texas’ HB2 did not protect women’s health and safety and in fact posed increased burden and risk to women seeking abortion care. In her concurring opinion, Justice Ginsburg cited the low complication rates associated with abortion, the conclusion of decades’ worth of research compiled and documented in briefs submitted to the Court by Social Science Researchers and the American College of Obstetricians and Gynecologists<sup>1</sup>.

Despite the evidence, state legislators continue to introduce and pass abortion restrictions across the country, and as they do researchers are documenting their impact on women’s health, access to care, and overall lives. In Ohio, researchers found that enforcement of an outdated protocol for medication abortion increased the odds of requiring follow up treatment as well as the likelihood of negative side effects<sup>2</sup>. And in Utah, a recent study confirmed that women have exceptionally high decisional certainty about their choice to have an abortion, directly challenging the argument that women benefit from legislatively forced waiting periods, multiple visits, and biased counseling<sup>3</sup>.

The findings on the harmful impact of abortion restrictions continues to grow, documenting everything from the impact of insurance bans and out of pocket cost on access to abortion care<sup>4</sup>, to average waiting time for appointments<sup>5</sup>, to the implications of abortion stigma in film and television<sup>6</sup>. Unfortunately, researchers are also increasingly targeted and harassed by anti-choice activists and legislators attempting to disrupt studies and threaten data dissemination<sup>7</sup>. As we head into 2017, it is clear that rigorous research must continue to be a priority for the true health and safety of women in the United States.





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## ***UNITED TO END BANS ON ABORTION COVERAGE***

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Activists made a big splash during this year's All\* Above All United for Coverage Week of Action, where more than 70 organizations and hundreds of individuals engaged in actions to support reinstating public funds for abortion coverage. These events aided awareness of the harms bans on abortion coverage cause, which disproportionately impact low-income women and women of color.



# TURNING THE TIDE: BRIGHT SPOTS IN THE 2016 STATE LANDSCAPE

While our primary progress on abortion rights in 2016 occurred in the courts with the game-changing decision in *Whole Woman's Health v. Hellerstedt*, legislators and advocates committed to advancing reproductive rights and justice made meaningful policy and advocacy progress in the areas of contraceptive access and maternal health.

Policymakers all across the country proposed bills intended to make contraception easier to obtain and more affordable. We tracked legislation that bans discrimination in the workplace related to reproductive health decision-making, makes it easier to obtain long-acting reversible contraception, and improves access to contraception in other creative ways. Additionally, several states considered legislation designed to increase access to data and review processes related to maternal mortality and other measures that will improve the quality of maternal health-care.

The proactive momentum we saw pick up dramatically [last year](#) shows no signs of slowing. Our victory in *Whole Woman's Health* offers myriad opportunities for reproductive health advocates to dismantle burdensome requirements on abortion providers that offer no medical benefit, as well as laws motivated by junk science. We are sure to see more bills calling for the repeal of harmful abortion restrictions, as well as those designed to proactively increase access to the full spectrum of reproductive health-care, in the 2017 legislative session.

Below, we provide a sampling of the legislative trends the Center is following closely in the states that have expanded access to abortion and contraception and improve maternal health.

## Expanding Abortion Access

### ARIZONA

The “Women’s Health Restoration Act” wins the prize for this year’s most jam-packed full-spectrum abortion access bill. The bill, SB 1407, would have repealed the majority of Arizona’s harmful abortion restrictions, while also increasing access to contraception and pregnancy planning education. This bill’s sponsors truly demonstrated that they will fight for the rights of Arizona women’s access to reproductive health options.

### PENNSYLVANIA

Pennsylvania advocates worked together with legislators to fulfill the promise of the *Whole Woman's Health* decision this summer. A coalition of pro-women’s health legislators introduced two bills attempting to repeal Pennsylvania’s law requiring abortion providers to meet hospital-like standards, which is similar to one of the Texas clinic shutdown laws struck down in *Whole Woman's Health*. Pennsylvania legislators also introduced SB 1105, a Freedom of Access to Clinic Entrances (FACE) Act designed to ensure that clinic entrances are free from violence and harassment. Additionally, Pennsylvania advocates and legislators ensured the introduction of HB 2331, a bill repealing the state’s harmful and discriminatory ban on abortion coverage in insurance plans sold on the state health insurance exchange.

### VIRGINIA

For five years, advocates in Virginia have been working tirelessly to roll back politically-motivated regulations that required first-trimester abortion providers to comply with hospital-like building standards. In October, they finally succeeded when the state Board of



Health voted to remove those medically unjustified building standards and other red tape requirements from the state’s abortion regulations. Women’s health experts lined up to testify against this clinic shutdown law, *Whole Woman’s Health* in hand, and the board listened, scrapping the egregious and unconstitutional regulations.

“*It was thrilling to watch Virginians passionately refer to our case as the new standard, affirming that no government can put forward restrictions like these without carrying out those laws’ ‘stated purpose,’ to advance women’s health and safety, basing regulations not on a politician’s feelings and beliefs, but rather on scientific evidence. I celebrate this victory as I celebrated the Whole Woman’s Health victory in June, as one that could transform the field of abortion care in the United States for a generation.*”

—AMY HAGSTROM MILLER, *Founder and CEO*, Whole Woman’s Health

## Expanding Contraceptive Access

It is crucial that women have meaningful access to contraception in order to be able to determine whether and when to have children. Restrictive insurance policies, financial difficulties, and the burdens associated with filling a prescription every month can interfere with a woman’s ability to access contraception in a timely manner. In 2016, several states responded to these real-world concerns, introducing or enacting laws aimed at making birth control easier to obtain and more affordable. Bills that allow women to receive up to 12 months<sup>1</sup> of contraceptives at one time were introduced in 16 states, and passed in 5 states. Measures that expand who can prescribe contraception or how it can be prescribed were introduced in 10 states and passed in 2 states. A snapshot of these policy developments to improve contraceptive access is below.

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<sup>1</sup> Maryland also passed a bill expanding access to contraception, though the amount of birth control that may be received at once is six months, not twelve.

Maryland legislators passed HB 1005 and SB 848, which, together, ban copayments for hormonal birth control and other FDA-approved contraceptive methods, as well as for permanent contraceptive solutions, such as sterilization. Additionally, these laws require that women are able to receive at least 6 months of a prescribed birth control at one time, greatly reducing the number of trips she would otherwise have to take to the pharmacy to fill her prescription. Vermont passed a similar law, HB 620, mandating all insurance plans to cover up to one year of FDA-approved birth control methods at a time. Hawaii and Illinois legislatures have followed suit, enacting SB 2319 and HB 5576, respectively. Eleven other states – Alaska, California, Colorado, Florida, Michigan, Minnesota, New Jersey, New York, Virginia, Washington, and Wisconsin – considered similar bills this year. These measures will help to alleviate the cost and inconvenience of obtaining contraception on a monthly basis.

This session, a number of states considered legislation that would broaden pharmacists’ authority to prescribe and dispense birth control and emergency contraception. In a region of the United States where access to reproductive health-care is often challenging, Tennessee enacted SB 1677, allowing pharmacists to directly dispense hormonal birth control to women. Hawaii extended this authority to registered advanced practice nurses (APNs) with the aforementioned SB 2319. Illinois, Missouri, New Jersey, New York, South Carolina, Washington, West Virginia, and Wisconsin legislatures also proposed similar measures designed to broaden the scope of pharmacists in order to expand contraceptive access.

Notably, advocates in California ensured the passage of CA SB 1433, a bill that would improve access to contraception and contraceptive counseling for incarcerated women, as well as ensure access to personal hygiene products. While not about expanding contraceptive access, another unprecedented victory was the long-fought repeal of the maximum family grant rule, a cruel, anti-family measure that unfairly limits the amount of public assistance families are able to receive based on the number of children they have.

## Supporting Maternal Health

All women have the right to safe and respectful maternal health-care that supports healthy pregnancies and births. In 2016, several states enacted bills to ensure access to quality health services and information for women before, during, and after pregnancy, as well as to ensure access to the social and economic resources to help them be as healthy as they can be.

Rates of maternal mortality are unacceptably high across the United States, and several states took steps to start addressing this problem. The U.S. is the only wealthy country where the rate of maternal death has gone up in the past 10 years, and experts believe that approximately 40% of U.S. maternal deaths are preventable. And regardless of income and education level, Black women are far more likely to die from pregnancy-associated causes, with a mortality rate three to four times that of White women.

One of the main barriers to eliminating these racial disparities and reducing the overall rate of mortality is the lack of adequate data to understand the causes of maternal mortality and morbidity. The federal government does not mandate states to report data on maternal death,





and states lack systems to monitor, analyze, and share data effectively. In 2016, Hawaii (SB 2317), South Carolina (HB 3251), Tennessee (SB 2303), and Washington (SB 6534) passed laws establishing maternal mortality review (MMR) processes. These processes—which are in place in over half the states—provide a mechanism for various stakeholders to review individual cases of maternal death, analyze trends, and make systems-level recommendations to improve maternal health outcomes for all. MMRs are most successful where they are legislatively created, adequately funded, and mandated to engage a broad range of stakeholders. Some states are actively engaging affected communities in the design and implementation of these processes. For example, Washington State’s Department of Health actively solicited applications from the public to serve on the state’s review panel, including midwives and other women’s health professionals.

States also passed laws to protect the rights of specific populations of pregnant women and parents. In Louisiana, legislators strengthened the legal protections for pregnant and parenting students through SB 353. This bill expands upon Title IX by requiring that all schools, including charters, implement sensible attendance policies that promote academic success while also ensuring a supportive learning environment for pregnant and parenting students. New York legislators sought to decrease the percentage of pregnant women who are uninsured by repealing the enrollment period requirement of the state’s health insurance exchange. Under SB 6429, pregnant women are able to enroll in the New York health insurance exchange at any time during the year rather than only in pre-designated times. Additionally, several states strengthened protections for pregnant women with respect to reasonable accommodations in the workplace for pregnancy, childbirth, breastfeeding, and related conditions, including Colorado (HB 1438), Utah (SB 59), and West Virginia (SB 195).



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# BLACK MAMAS MATTER

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As an anchor organization of Black Mamas Matter, a network we co-founded in 2015 with SisterSong Women of Color Reproductive Justice Collective, we are tackling the growing U.S. maternal health crisis. Recent studies show the U.S. is the only wealthy country where the rate of maternal death has gone up in the past 10 years—and Black women are disproportionately impacted.

Using our policy expertise, we are supporting a growing network of Black women leaders who are raising the visibility of this crisis and promoting solutions. In June 2016, we launched a new resource for state advocates, titled *Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health-care*. The toolkit offers research on the causes of maternal mortality, a human rights analysis of the issue, and a menu of rights-based policy solutions to eliminate racial disparities and improve maternal health outcomes. Moving forward, in partnership with the Black Mamas Matter steering committee, we will build the community and legislative support to translate the toolkit's recommendations into policy change.





# STATE SPOTLIGHT: OKLAHOMA ADVOCATES IN ACTION

The 2016 legislative session was a year unlike any other for the Oklahoma Coalition for Reproductive Justice (OCRJ). In May, the Oklahoma legislature passed SB 1552, the most drastic effort yet by Oklahoma lawmakers to curtail access to abortion. The bill was an unprecedented measure which would have outlawed abortions in all cases. SB 1552 would have made providing abortion a felony punishable by up to three years in prison and would have stripped physicians who provide abortions of their medical licenses.

When faced with one of the most extreme abortion bills they had ever seen, OCRJ knew they had to get creative. These exceptional state advocates, like many other Oklahomans,

found themselves frustrated by the constant need to defend abortion rights while their state suffered a budgetary crisis and continued to be in dire need of educational training. By harnessing an intersectional approach to their advocacy, OCRJ was able to unify many people around abortion rights by calling out the vital issues their lawmakers were ignoring. The idea of discussing other important matters such as paid family leave, a full-spectrum approach to women's health policy, and combating sexual assault resonated with many Oklahomans who were not already involved in OCRJ's work defending abortion access.

Inspired by Indiana's #PeriodsforPence campaign, OCRJ also created a virtual way for Oklahomans who couldn't make it to the capital to speak out against the bill with their *Ask an Oklahoma Gynotician* social media event. *Ask an Oklahoma Gynotician* provided resources for citizens to call or email their lawmakers to discuss their personal reproductive matters as a creative, bold way of reminding legislators that SB 1552 would infringe on their private medical decisions.

Governor Mary Fallin ultimately vetoed the bill before it took effect, stating that SB 1552 would not stand up to a costly legal challenge. Governor Fallin's veto showed that advocacy can work; historically, she has signed other abortion restrictions into law. For Oklahoma, 2016 proved to be a year with exceptional challenges that called for distinct advocacy solutions, and OCRJ rose to the occasion.



“The 2016 legislative session was unique for OCRJ, as it was the first time in a decade an abortion restriction was not passed into law. Our state's budgeting issues allowed many Oklahomans to express their frustration with our legislature wasting resources on unconstitutional abortion restrictions. Likewise, we wanted to create a dialogue regarding broader reproductive issues, like comprehensive sexual education and paid family leave, as reproductive justice is an integral part of OCRJ's work. Using that framework for our outreach during the 2016 legislative session, we gained the backing of those Oklahomans who typically do not support our work regarding abortion access, yet recognized the extremism of 2016's anti-choice bills as well as the need for focus on more important issues within our state.”

—MICALA WOOD,  
Oklahoma Coalition for Reproductive Justice

(Pictured: The powerful coalition of advocates rallied at the Oklahoma state capitol against SB 1552.)

# A PIVOTAL YEAR FOR ABORTION RIGHTS IN THE COURTS

In 2016, as in other recent years, federal and state courts served as a crucial line of defense for the right to choose and access abortion, stepping in to block laws when legislatures passed devious restrictions on access to reproductive health-care.

But this year was not business as usual in the courts; the Supreme Court delivered a watershed victory for the reproductive rights movement when it handed down *Whole Woman's Health* on June 27, 2016. *Whole Woman's Health* struck down the two Texas TRAP (“targeted regulation of abortion providers”) laws, preserving access for millions of women in Texas. At the same time, it clarified that the “undue burden” standard – the legal test that courts have used to evaluate abortion laws since 1992 – provides robust protection for the right to choose abortion.

*Whole Woman's Health* sounded a death knell for similar TRAP laws that were making their way through the courts. Showing that the Supreme Court's decision broadly strengthened abortion rights – with effects that are only beginning to unfold – the courts in 2016 also rejected a range of other abortion restrictions, some of them nascent laws that anti-choice advocates have been debuting as alternatives to TRAP. *Whole Woman's Health* certainly didn't immediately invalidate abortion restrictions other than the two Texas restrictions at issue in the case, and its impact will evolve over time. However, the case has already shifted the balance in courts nationwide, where harmful, burdensome laws now face a stringent legal standard, and some states have already pulled back from even trying to defend them.

**The Supreme Court decision and other key legal developments from 2016 are highlighted below.**

## *Whole Woman's Health:* The Constitution Prohibits Sham Abortion Restrictions

TRAP laws saddle abortion providers with regulations that purportedly protect women's health – but in fact, are disguised attempts to make abortion care difficult or impossible to provide. TRAP laws can even force high-quality, long-serving providers to shut down because they cannot comply with regulations that are unnecessary, expensive, and devoid of any health or safety benefits. State legislators have passed a wave of TRAP laws in recent years, in part because they hoped the laws would survive judicial scrutiny under the undue burden legal standard.

*Whole Woman's Health* involved two TRAP provisions in the omnibus 2013 Texas law known as HB2: the provision requiring all abortion providers to obtain local hospital admitting privileges, and the ambulatory surgical center (ASC) provision requiring every licensed abortion facility to meet hospital-like building standards.

While the state of Texas claimed that it enacted these laws to advance its interest in women's health by making abortion safer, evidence at trial showed that the laws did not offer any health or safety benefits. At the same time, the evidence showed that they would cause most of Texas' clinics to close, leaving the state with just a few clinics clustered in urban areas and thousands of women without adequate access. The trial court blocked both provisions as unconstitutional, holding that the lack of valid health benefits, combined with the significant burden on women's access, rendered them an undue burden. On appeal, the Fifth Circuit insisted that the undue burden standard did not require or even allow the court to assess whether the restrictions actually conferred health benefits on women as the state asserted.





In November 2015, the Supreme Court granted certiorari in *Whole Woman's Health*, almost nine years since it last heard a case about abortion rights. The Court handed down its opinion on June 27, 2016. Justice Stephen Breyer wrote for the majority, striking down both the admitting privileges requirement and the ASC requirement. *Whole Woman's Health* explained that courts must “consider the burdens a law imposes on abortion access together with the benefits those laws confer.” With regard to benefits, the Supreme Court held that neither restriction was medically justified, since they provided “few, if any, health benefits for women.” To reach this conclusion the Court conducted a detailed analysis of whether any medical or “research-based” evidence justified the law, concluding – contrary to Texas’ claims, and explicitly rejecting junk science – that the laws were unnecessary.

Turning to the burdens on women, the Court identified a wide range of burdens that the restrictions imposed, including clinic closures, increased travel distances, fewer doctors, overcrowded conditions, longer waiting times, and less opportunity for individualized medical attention. It explained that any purported health benefits were not “sufficient to justify the burdens upon access that each imposes,” and thus held that each provision “constitutes an undue burden on abortion access,” thereby violating the U.S. Constitution.

*Whole Woman's Health* is a major victory for abortion rights – and not just in Texas. Going forward, courts across the country must balance any benefits that an abortion restriction offers against the burdens it places on women, and strike down the law if its burdens outweigh its benefits. Laws that do not actually advance a valid state interest – in women’s health or otherwise – are constitutionally flawed and must be struck down by courts. Courts cannot defer to legislators who make claims about a law’s benefits or burdens with nothing but junk science to back them up. Instead, they have an obligation, when constitutional rights are at issue, to independently assess credible evidence and reach their own conclusions.



## Whole Woman’s Health Shifts the Balance in Courts Nationwide

The effects of *Whole Woman’s Health* began to ripple through the lower courts almost immediately, where TRAP challenges were pending in different stages of litigation. Showing that the clarified standard applies beyond the TRAP context, courts also ruled against other types of abortion restrictions that failed to advance women’s health or other legitimate state interests. In the wake of the *Whole Woman’s Health* decision, some other states decided not to defend their laws further in court.

### TRAP LAWS FALL

Every court that evaluated a TRAP law in 2016 blocked it from taking effect. Major case developments in this section show how the *Whole Woman’s Health* decision had immediate and ongoing positive effects on pending cases.

#### OHIO

##### ***Capital Care v. Ohio Department of Health***

**(Court of Appeals Sixth Appellate District, July 2016; appeal in progress as of late 2016)**

✓ **Transfer agreement law - Blocked**

*Capital Care* challenged an Ohio law requiring outpatient facilities that provide abortions to maintain a written transfer agreement with a local hospital, while also prohibiting public hospitals from making agreements with facilities that provide abortions. An abortion provider who could not find a hospital to contract with and had its license revoked brought suit (represented by the ACLU), and a trial court found the law unconstitutional as applied to the provider in June 2015. Ohio appealed, arguing that the law did not create an undue burden under the U.S. Constitution. Relying on *Whole Woman’s Health* to apply the required balancing test, the appellate court found that the law imposed an undue burden. On the benefits side, the court found that the need for a hospital transfer for an abortion patient was “just about nonexistent,” noting that “the need has not arisen in the past twelve years.” On the burdens side, closure of the clinics would increase travel time and travel expenses, and might increase wait times, cause anxiety, and decrease the attention that medical staff could give each patient. The court blocked the law as a textbook violation of *Whole Woman’s Health*, prompting the state to file an appeal to the Ohio Supreme Court that was pending as of late 2016.

#### LOUISIANA

##### ***June Medical Services v. Kliebert***

**(Federal District Court, January 2016; final decision expected as of late 2016)**

✓ **Admitting privileges - Blocked**

In *June Medical Services*, doctors and clinics (represented by the Center) challenged a Louisiana state TRAP law that required doctors to have admitting privileges at a local hospital.

In January, a district court judge blocked the law because it would have caused most of the safe, long-serving clinics in the state to close. In an unusual last minute maneuver, the state of Louisiana asked the U.S. Court of Appeals for the Fifth Circuit to allow the law to go into effect on an emergency basis, and the Fifth Circuit agreed. Fortunately for Louisiana women, the U.S. Supreme Court stepped in, granting the clinics’ urgent petition to keep the law blocked so they could remain open. After the *Whole Woman’s Health* decision came down in June, the Fifth Circuit dismissed Louisiana’s appeal of the preliminary injunction and sent the case back to the district court, which will now evaluate whether the law’s absence of actual health and safety benefits combined with the burden it placed on women renders it unconstitutional. A final opinion was pending as of late 2016.

#### ALABAMA

##### ***Planned Parenthood v. Strange***

**(Federal District Court, March, 2016; appeal dismissed August 2016)**

✓ **Admitting privileges - Blocked**

*Planned Parenthood v. Strange* was a challenge brought by clinics (represented by the ACLU and PPFA) against Alabama’s admitting privileges requirement, which required doctors to maintain privileges at a local hospital. In 2014, a federal district court found the law to be unconstitutional, but requested additional input on whether the unconstitutional parts could be removed from the law while retaining other requirements. In March of this year, the court’s final opinion rejected the state’s request to preserve a weaker but still problematic requirement for doctors to have admitting privileges at *any hospital in the world* that would grant them. The court found that this modified requirement had even weaker health and safety justifications than the original admitting privileges requirement, since it contradicted Alabama’s claim at trial that it sought to advance women’s health by ensuring women could be admitted at a nearby hospital in order to provide continuous care. The law’s lack of actual benefits, combined with its burden on women, made it unconstitutional. While the state initially filed an appeal to the U.S. Court of Appeals for the Eleventh Circuit, it later asked the court to dismiss its own case after the Supreme Court issued *Whole Woman’s Health*.

#### ARKANSAS

##### ***Planned Parenthood Arkansas & Eastern Oklahoma v. Jegley***

**(Federal District Court, March 2016; appeal in progress as of late 2016)**

✓ **Contracted physician requirement - Blocked**

In *Planned Parenthood v. Jegley*, abortion providers represented by Planned Parenthood and the ACLU challenged an Arkansas law that required all providers who offer medication abortion to contract with a doctor who had admitting privileges and surgical privileges at a hospital. In March, the court blocked the law while litigation continued because the evidence suggested that the state’s interest in regulating medication abortion through the contracted physician requirement is “low and not compelling.” Even if it ignored the lack of health and safety benefits, the court found that the burden on women alone was enough to invalidate the law. Arkansas appealed to the U.S Court of Appeals for the Eighth Circuit in May 2016,



seeking to enforce the law while litigation moved toward a final judgment. The Supreme Court decided *Whole Woman’s Health* in the meantime, which will significantly weaken the state’s case if it continues to pursue its appeal.

As these cases show, *Whole Woman’s Health* dealt, or will soon deal, a final blow to TRAP laws in many states. Even before 2016’s legal developments, courts had blocked TRAP laws in Oklahoma, Tennessee, Mississippi, Wisconsin, and Kansas. In Mississippi and Wisconsin, state officials had asked the U.S. Supreme Court to reverse decisions that blocked admitting privilege mandates and issue a legal standard that would protect copycat TRAP laws in other states. After deciding *Whole Woman’s Health*, the Supreme Court refused to hear the Mississippi and Wisconsin cases. Under the *Whole Woman’s Health* legal standard, these past decisions are safe, and unnecessary laws that burden women will be struck down in the future.

## BEYOND TRAP: COURTS BLOCK EMERGING AND EXCESSIVE RESTRICTIONS

Even outside the TRAP context, in 2016 courts nationwide turned a skeptical eye on abortion laws that seemed unnecessary or excessive, choosing not to defer to states that tried to justify them as legitimate. Some of the challenged laws were new types of restrictions that the anti-choice movement has been pushing as alternatives to TRAP laws. The new restrictions – among them fetal tissue burial requirements and bans on abortion methods – fared poorly in courts in 2016. And as the following cases show, in some instances, states responded to the legal sea change that *Whole Woman’s Health* created by declining to defend some of their own laws, instead choosing to settle cases before trial or forgo appeal.

### OKLAHOMA

#### ***Burns v. Cline***

**(Oklahoma Supreme Court, October 2016)**

✓ **Omnibus anti-abortion law - Blocked**

*Burns v. Cline* is a challenge to a sprawling omnibus law passed by the Oklahoma legislature. Among other provisions, the law creates additional and sweeping criminal penalties for a variety of abortion regulations and permits warrantless searches of abortion clinics. The Center represented a local provider who challenged the law on the grounds that it violated a clause in the state Constitution that requires laws to address a single subject. The Oklahoma Supreme Court agreed, permanently blocking the law. A concurring judge wrote that the law also violated the undue burden standard as clarified in *Whole Woman’s Health* because it “creates an open-ended array of regulatory hurdles ....[that] will make it considerably more difficult for providers to operate, and accordingly will make it more difficult for the women of Oklahoma to exercise their federally-recognized constitutional right to control their own reproductive futures.”

### FLORIDA

#### ***Planned Parenthood of Southwest and Central Florida v. Philip***

**(Federal District Court, August 2016)**

✓ **Omnibus law - Blocked**

Showing typical zeal for sprawling abortion statutes that regulate every aspect of care in unnecessary and harmful ways, the Florida legislature passed an omnibus anti-abortion law that included a prohibition on abortion providers receiving any state funds and an onerous requirement that 50% of all patient records be inspected annually, described fully on page 10. When clinics challenged the law (represented by Planned Parenthood), a federal district court blocked the defunding and records-inspection requirements, finding them likely unconstitutional just three days after the Supreme Court decided *Whole Woman’s Health*. Instead of appealing, the state agreed not to enforce any of the provisions and the court permanently blocked the law in August.

### INDIANA

#### ***Planned Parenthood of Indiana and Kentucky v. Commissioner,***

***Indiana State Department of Health***

**(Federal District Court, June 2016)**

✓ **Fetal Tissue Burial Mandate and Reason Ban - Blocked**

Indiana clinics (represented by Planned Parenthood and the ACLU) challenged a law, described on page 11, that required an abortion clinic or health-care facility to arrange for burial or cremation of fetal tissue. The law also banned abortion if sought on account of the fetus’s race, color, national origin, ancestry, sex, or disability, and required doctors to inform women about this prohibition. The district court, in the first recent decision in the nation to address a fetal tissue burial law, blocked both provisions early in litigation. The court rejected the state’s claim that it had a legitimate interest in “treat[ing] fetal remains with the same dignity as other human remains,” noting that the Supreme Court has held unequivocally that a fetus is not a person under the law. Accordingly, the court held that laws that try to mandate burial or cremation of an embryo or fetus after abortion are unrelated to any legitimate state interest, which makes them unconstitutional as a matter of settled law. The court also held that pre-viability bans on abortion – irrespective of the reason – have been clearly unconstitutional ever since *Roe v. Wade*. The state decided not to appeal the court’s preliminary decision to block the laws, and the case was moving forward as of late 2016.

### KANSAS

#### ***Hodes & Nauser v. Schmidt***

**(Kansas Court of Appeals, January 2016; appeal in progress as of late 2016)**

✓ **D&E Ban - Blocked**

*Hodes & Nauser* is a challenge that providers (represented by the Center) brought against a first-of-its-kind Kansas law that bans the most common method for performing abortion in the second trimester. Anti-abortion organizations have recently advocated for copycat legislation





Activists awaited the decision outside the Supreme Court.



in state legislatures across the country, with six states enacting bans on the standard D&E procedure as of today. Legal challenges followed: trial courts in Oklahoma, Alabama, and Kansas blocked D&E bans in the early stages of litigation, and Louisiana agreed not to enforce its ban against licensed abortion clinics or their physicians while litigation proceeds. The Kansas D&E ban is the first law to be ruled on by an appellate court – the Kansas Court of Appeals – which held that the law likely violates the Kansas Constitution. The court held that the state simply cannot ban the most common method of abortion, leaving only less-used alternatives available to women, writing that “[g]iven the additional risk, inconvenience, discomfort, and potential pain associated with these alternatives, some of which are virtually untested, we conclude that banning the standard D&E, a safe method used in about 95% of second-trimester abortions, is an undue burden on the right to abortion.” Kansas appealed to the Kansas Supreme Court, which is expected to hear argument in early 2017.

## LOUISIANA

***June Medical Service et al. v. Gee***  
**(Federal District Court, filed July 2016)**

Following its tradition of adopting the broadest range of anti-choice laws possible, Louisiana passed seven different bills restricting access to abortion in 2016 – the most of any state. The package includes a ban on the standard D&E procedure, a fetal tissue burial or cremation mandate, a de facto ban on medication abortion, an extended waiting period (increased to 72 hours), funding restrictions, and additional harmful provisions, described on page 13. The Center challenged all seven laws before they took effect, and the state agreed temporarily not to enforce them. The legal challenge turns on the enormous burdens that the laws - individually and together – place on women, combined with their failure to properly advance health and safety or any other legitimate state interest. Litigation will continue in 2017.

## Courts Reject Other Harmful Abortion Restrictions

In addition to rejecting TRAP laws and emerging restrictions, courts blocked other types of abortion laws in 2016 – including some of the usual suspects pushed by the anti-choice movement that have spread across many states, partly because courts in past years were willing to uphold them. These cases are notable because courts decided them under state constitutions, an alternative source of legal protection against abortion restrictions.

### ALASKA

***Planned Parenthood of the Great Northwest v. State of Alaska***  
**(Alaska Supreme Court, July 2016)**

✓ **Parental Notice Law – Blocked**

In *Planned Parenthood of the Great Northwest*, Alaska clinics and doctors (represented by *the Center*) challenged a law that required clinics to notify parents at least 48 hours before providing an abortion to a minor. The trial court upheld the law. The Supreme Court reversed, finding that the law violated the Alaska Constitution’s equal protection clause because minors who choose abortion are legally equal to minors who choose to carry to term, and the state lacked a compelling reason for discriminating against minors who choose abortion.

### FLORIDA

***Gainesville Woman Care v. State of Florida***  
**(Florida Supreme Court, argued November 2016)**

✓ **Waiting Period Law – Blocked**

*Gainesville Woman Care* is a challenge brought by a Florida provider and medical students’ association (represented by the Center and the ACLU) against a law requiring women to make two trips to a clinic and wait at least 24 hours between the trips before they can receive an abortion. The providers argued that the law violates the right to privacy guaranteed by the Florida Constitution, which provides the strongest possible protections for abortion rights. Last year, the trial court agreed that the law is likely unconstitutional and blocked it pending final resolution of the case. A state appellate court reversed in February 2016 and allowed the law to go into effect – burdening Florida women who faced the extra expenses, time, and stress that scheduling an unnecessary appointment at a sometimes distant clinic entailed. The Florida Supreme Court then stepped in to keep the law blocked while it heard arguments in November 2016. The court’s opinion was pending as of late 2016.



## States’ Defunding Attempts are Blocked Across the Board

Following anti-choice activists’ attempt to smear Planned Parenthood through the release of illegally obtained, deceptively edited videos in the summer of 2015, a number of states took actions to withhold funding (Medicaid reimbursement in some states, and additional types of funding in others) from Planned Parenthood and other abortion providers. While most of these states already prohibited state funds from being used to provide abortions, they now seek to cut off funds used for other reproductive health services such as STD testing, contraception, and pre and post-natal care. Clinics and patients who stood to lose their healthcare challenged defunding actions in several states.

Almost every court that reached a decision on a defunding attempt in 2016 blocked implementation, holding that it was illegal or likely to be illegal under federal law - and in some cases the federal Constitution. The Federal law that prohibits unjust attempts to cut off Medicaid is called the Medicaid Act, and it guarantees Medicaid patients the right to choose any willing, qualified provider to obtain health-care. Finding that targeted clinics were highly qualified, every court except a single district court in Utah blocked defunding attempts (and the Utah decision was promptly reversed on appeal). When states cut off non-Medicaid grants, courts found that the federal Constitution does not allow states to defund clinics in order to punish them for engaging in constitutionally protected activity. Faced with probable legal defeat, some states in 2016 decided not even to move forward with their defunding plans.

### MEDICAID DEFUNDING CASES

#### ARKANSAS

***Planned Parenthood Arkansas & Eastern Oklahoma v. Selig***  
(Federal District Court, January 2016)

In October 2015 a district court blocked Medicaid defunding while the case proceeds. Arkansas appealed to the Eighth Circuit, with a ruling awaited as of late 2016. Meanwhile, the district court extended the protections to a broader group of patients and clinics in January 2016.

#### KANSAS

***Planned Parenthood of Kansas and Mid-Missouri v. Mosier***  
(Federal District Court, July 2016)

A district court blocked Medicaid defunding while the case proceeds. The state’s appeal to the U.S. Court of Appeals for the Tenth Circuit was in progress as of late 2016.

#### ARIZONA

***Planned Parenthood Arizona v. Betlach***  
(Federal District Court, September 2016)

Arizona promised not to proceed with Medicaid defunding after clinics filed suit, and the plaintiffs agreed to have the case dismissed.

#### LOUISIANA

***Planned Parenthood Gulf Coast v. Kliebert***  
(Fifth Circuit, September 2016)

Louisiana appealed to the Fifth Circuit after a federal district court blocked Medicaid defunding while litigation proceeded. In September 2016, the Fifth Circuit affirmed that defunding should remain blocked pending final resolution of the case because Louisiana’s actions likely violated federal law.

#### MISSISSIPPI

***Planned Parenthood Southeast v. Dzielak***  
(Federal District Court, October 2016)

A district court permanently blocked the state’s Medicaid defunding law at the beginning of litigation, holding that “Essentially every court to consider similar laws has found that they violate [federal law].”

### CONSTITUTIONAL DEFUNDING CASES

#### UTAH

***Planned Parenthood Association of Utah v. Herbert***  
(Tenth Circuit, July 2016)

Utah’s defunding directive withdrew non-Medicaid funds from Planned Parenthood that had been used for STD treatment programs and youth education. Planned Parenthood sued to block the directive on constitutional grounds, but a district court – issuing the only 2016 opinion that approved a defunding attempt - held that it was likely constitutional and could take effect while the case moved forward. The Tenth Circuit reversed and blocked the law, holding that Utah’s defunding plan likely violated Planned Parenthood’s First and Fourteenth Amendment rights to provide abortions and advocate for abortion access.

#### FLORIDA

***Planned Parenthood of Southwest and Central Florida v. Philip***  
(Federal District Court, August 2016)

As described above, the Florida legislature passed an omnibus anti-abortion law that included a prohibition on abortion providers receiving any state funds for non-abortion services such as education and STD testing (abortion funding was already barred). A federal district court blocked the defunding attempt, holding that the state could not withhold funds from clinics simply because they were engaging in their constitutionally-protected right to provide abortions. Instead of appealing, the state agreed not to move forward with defunding and the court permanently blocked the law in August.





## OHIO

### ***Planned Parenthood of Greater Ohio v. Hodges*** (Federal District Court, August 2016)

Ohio's defunding law withdrew non-Medicaid funds for a range of programs dealing with STD testing, domestic violence prevention, infant mortality, and breast cancer treatment from entities that perform or promote abortions, or contract or affiliate with any entity that does as much. Providers challenged the law on constitutional grounds, and the district court permanently blocked it as a violation of clinics' First and Fourteenth Amendments to provide abortions and advocate for abortion access. Ohio filed an appeal in the Sixth Circuit that was in progress as of late 2016.

In sum, courts in 2016 almost unanimously rejected state attempts to withhold funding for non-abortion programs and services from providers, averting the crisis for women's health that these ill-advised actions would have created.

## Medication Abortion

### **FOOD AND DRUG ADMINISTRATION (FDA) LABEL CASES RESOLVED**

This was also a favorable year for challenges to another type of anti-choice legislation that had recently gained traction in state legislatures: FDA label mandates for medication abortion, which required doctors who prescribed the drug to follow an outdated protocol that the FDA approved almost two decades ago, before evidence-based research showed that a newer protocol was safer, cheaper, and more effective. As a result, state laws requiring doctors to use the FDA protocol forced them either to subject women to a medically inferior regimen or stop providing medication abortion altogether. As of early 2016, doctors and clinics were challenging these FDA label laws in Arizona, Arkansas, Ohio, and Oklahoma.

In March 2016, the FDA announced that it had approved a change to the drug label that adopted the evidence-based protocol. As a result, many cases that were pending in the courts were favorably affected. For example, litigation in Ohio settled in May 2016 after the state decided not to enforce its law. The Arizona legislature went a step farther, actually repealing its FDA label statute – and another law that required doctors to tell women that medication abortion could be reversed, although methods to do so were untested, unproved, and possibly dangerous, both of which were subject to litigation. As of late 2016, only Oklahoma is continuing to defend FDA label laws against legal challenges, and even there, the court blocked enforcement while litigation continues. Because FDA label laws provide no health or safety benefits to women – and at the same time burden access – they fall squarely within the Supreme Court's unconstitutional zone in *Whole Woman's Health*, which signals that states' last ditch efforts to revive their FDA label laws will not succeed.



# 2016 QUICK REFERENCE: MAJOR DEVELOPMENTS IN ABORTION RIGHTS LITIGATION

***Whole Woman's Health v. Hellerstedt:*** The U.S. Supreme Court struck down two Texas restrictions that would have closed most of the clinics in the state, holding that “health and safety” laws that restrict access without improving health or safety are unconstitutional under the proper legal test. The decision also casts doubt on other types of laws that burden women’s access without offering legitimate benefits.

***June Medical Services v. Kliebert:*** A federal district court preliminarily blocked Louisiana’s clinic shutdown law that required doctors to have admitting privileges at a local hospital, finding it would close most clinics in the state. The U.S. Supreme Court intervened to keep the law blocked after Louisiana took emergency action in the Fifth Circuit to enforce it. The case is now back in district court where the judge is expected to permanently block it.

***Hodes & Nauser v. Schmidt:*** The Kansas Court of Appeals affirmed a district court’s holding that Kansas’ ban on the most common method for providing abortion in the second trimester should be preliminarily blocked. Kansas appealed to the Kansas Supreme Court, which is expected to hear argument in early 2017.

***Planned Parenthood v. Strange:*** A federal court permanently blocked Alabama’s clinic shutdown law that required doctors to have admitting privileges at a local hospital and rejected a proposed change to the law that would make it even less likely to offer any health or safety benefits. The state dismissed its own appeal, which makes the decision final.

***Planned Parenthood Arkansas & Eastern Oklahoma v. Jegley:*** A federal court preliminarily blocked Arkansas’ clinic shutdown law that required doctors who provide medication abortions to have privileges at a local hospital. The state has appealed to the Eighth Circuit.

***Planned Parenthood of Indiana and Kentucky v. Commissioner, Indiana State Department of Health:*** A federal district court preliminarily blocked an Indiana law requiring providers to arrange for fetal tissue to be buried or cremated, and banning abortion if sought on account of the fetus’s race, color, national origin, ancestry, sex, or disability. The state decided not to appeal, and the case is moving forward while the law remains blocked.

***Planned Parenthood of the Great Northwest v. State of Alaska:*** The Alaska Supreme Court found that Alaska’s law requiring clinics to notify parents and wait 48 hours before providing an abortion to a minor violated the state Constitution. A trial court had upheld the law, but the Supreme Court reversed, permanently blocking enforcement.

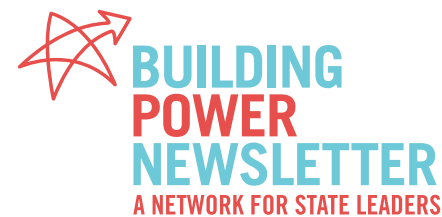
***Capital Care v. Ohio Department of Health:*** An Ohio appellate court affirmed that a state law requiring abortion clinics to maintain a transfer agreement with a local hospital, while also prohibiting public hospitals from making agreements with clinics, was unconstitutional as applied to a provider that had its license revoked because it could not find a local hospital to contract with. The state has appealed to the Ohio Supreme Court.



**Planned Parenthood of Southwest and Central Florida v. Philip:** A federal district court preliminarily blocked Florida’s omnibus law that included funding restrictions, a records inspection requirement, and vague definitions of medical terms on which licensing decisions depended. The state decided not to appeal or pursue enforcement, and the court permanently blocked the law by agreement of the parties.

**Burns v. Cline:** The Oklahoma Supreme Court permanently blocked Oklahoma’s kitchen sink anti-abortion law that 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. It found the law was unconstitutional under the Oklahoma state Constitution, which requires laws to address a single subject.

**Gainesville Woman Care v. State of Florida:** A Florida appellate court held that Florida’s law requiring women to wait 24 hours after visiting a clinic and return for a second visit in order to receive an abortion could go into effect, reversing a district court’s decision to block it because it likely violated the state Constitution. The Florida Supreme Court intervened to keep the law blocked and agreed to hear the case. The court’s opinion was pending as of late 2016.



#### For More Information and Technical Assistance

The Center is proud to support independent abortion providers and state advocates around the country. For more information or technical assistance, or to sign up for our quarterly e-newsletter on state policy developments and resources, please contact **Ashley Gray** at [agray@reprorights.org](mailto:agray@reprorights.org). Please contact **Jennifer Miller**, [JMiller@reprorights.org](mailto:JMiller@reprorights.org), for all press inquiries.





Endnotes

<sup>1</sup> *Whole Woman’s Health v. Hellerstedt*, 579 U.S. \_\_\_\_ (2016), *available at* [http://www.supremecourt.gov/opinions/15pdf/15-274\\_p8k0.pdf](http://www.supremecourt.gov/opinions/15pdf/15-274_p8k0.pdf)

<sup>2</sup> Upadhyay, Ushma D., Nicole E. Johns, Sarah L. Combellick, Julia E. Kohn, Lisa M. Keder, and Sarah CM Roberts. “Comparison of Outcomes before and after Ohio’s Law Mandating Use of the FDA-Approved Protocol for Medication Abortion: A Retrospective Cohort Study.” *PLoS Med* 13, no. 8 (2016) *available at* <http://www.ansirh.org/news/ohio-law-restricting-medication-abortion-did-not-improve-health-outcomes>

<sup>3</sup> Ralph, Lauren J., Diana Greene Foster, Katrina Kimport, David Turok, and Sarah CM Roberts. “Measuring decisional certainty among women seeking abortion.” *Contraception* (2016) *available at* [http://www.contraceptionjournal.org/article/S0010-7824\(16\)30410-3/abstract](http://www.contraceptionjournal.org/article/S0010-7824(16)30410-3/abstract)

<sup>4</sup> Ibis Reproductive Health and All Above All. “Research Brief: The impact of out-of-pocket costs on abortion care access.” (September 2016) *available at* <http://www.ibisreproductivehealth.org/publications/research-brief-impact-out-pocket-costs-abortion-care-access>

<sup>5</sup> Jones, Rachel K., and Jenna Jerman. “Time to Appointment and Delays in Accessing Care among US Abortion Patients.” (2016) *available at* <https://www.guttmacher.org/report/delays-in-accessing-care-among-us-abortion-patients>

<sup>6</sup> See <http://www.ansirh.org/research/abortion-onscreen>

<sup>7</sup> See Massoud Hayoun ‘Missouri state senator aims to block student’s dissertation on abortion’ (Nov. 11, 2015) *Al Jazeera* *available at* <http://america.aljazeera.com/articles/2015/11/11/missouri-senator-aims-to-block-students-dissertation-on-abortion.html>; Alexa Ura ‘Source: Delayed Texas Abortion Data Finished Months Ago’ (June 22, 2016) *The Texas Tribune* *available at* <https://www.texastribune.org/2016/06/22/source-texas-abortion-data-has-been-final-months/>

Photos on page 34, 46, and 51 were taken by Mike Morgan for the Center for Reproductive Rights.

Notes



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