

2013 MID-YEAR REPORT

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INTRODUCTION

For over 40 years, women in the United States have had the right to access safe, legal abortion. Women, in consultation with their families and their doctors, make decisions about the course of their reproductive lives every day—whether to use contraception, to try to start a family, or, when faced with an unintended pregnancy, to choose adoption, end the pregnancy, or raise a child. These decisions are among the most personal and private any person can make—and they are not decisions that should be dictated by politicians. Nonetheless, every year, those who oppose abortion and contraception propose hundreds of laws in state legislatures across the country that are intended to make it harder for women to access reproductive health care, to protect their health and lives, and to plan their childbearing. This push to roll back women’s rights hit a high-water mark in 2011, with a record number of harmful laws passing. This year, a new extreme was reached, as some of the most harmful and insidious legislation proposed in the forty years since *Roe v. Wade* has now become law. At the halfway point in the year, more than two dozen harmful bills have become law in 15 states, with more bills pending in several other states.

In the face of the latest assault on women’s health and rights, citizens, advocates, and champion legislators throughout the country have tirelessly stood up for women and access to reproductive health care. No better example of this stalwart advocacy exists than the remarkable filibuster by Senator Wendy Davis of Texas on the last day of the Texas special session, supported by hundreds of Texans in the gallery and thousands more urging her on from around the state and around the country.

And in some cases, when these types of laws have passed, the Center for Reproductive Rights and other organizations have already challenged many of the most extreme and unconstitutional laws in court. As the 2013 session continues, the Center stands with our allies to protect and defend women’s health, rights, and ability to make the right decisions for themselves and their families.

The following report summarizes some of the trends we have observed thus far in 2013 and highlights some of the most dangerous bills that have become law this year.

MAJOR TRENDS IN 2013

BANS

GESTATIONAL LIMITS

Over the last several years, anti-abortion activists and politicians have mounted a campaign to pass unconstitutional bans on abortions later in pregnancy. Since 2010, 12 bans on abortion at either 20 weeks post-fertilization age or at 20 weeks dated from a woman's last menstrual period (Lmp) have become law. Three of these bans have been challenged in court, and all three have been enjoined by a court preliminary or permanently. In 2013, however, anti-abortion groups pushed the constitutional bounds even further, introducing bans on abortion as early as six weeks in pregnancy. This year, two states banned abortion in the first trimester: Arkansas at 12 weeks Lmp and North Dakota around 6 weeks Lmp. Both laws are blatantly unconstitutional and have been challenged by the Center for Reproductive Rights in federal court. Arkansas's ban has already been preliminarily enjoined by a federal court. *See below for more details on these laws and the Center's litigation.*

Not content with banning abortion early in pregnancy, Arkansas and North Dakota also passed bans on abortion at 20 weeks post-fertilization age. At least ten states considered bans on abortion at 20 weeks, with legislation still pending in four states. Moreover, bans on abortion as early as 6 weeks Lmp were proposed and rejected in three other states.

REASONS-BASED BANS

Anti-abortion activists and legislators have also tried to limit access to abortion by banning abortions sought for particular reasons. At least 15 states considered legislation that would police women's reasons for seeking abortions and would prohibit abortions sought for particular reasons. Most of these bills would prohibit a physician from performing an abortion under the threat of criminal penalties if he or she believes that the patient is seeking the abortion because of the sex of the fetus. Gender-based discrimination is a deeply rooted societal problem. Where it exists, it should be condemned and addressed by both governments and private actors. The evidence, however, shows that bans on sex-selective abortion are both inappropriate and ineffective policy. They do not remedy the core problem of discrimination against women and girls, and they threaten the health and human rights of women by creating additional barriers to obtaining legal abortions. Although they purport to address discrimination, in reality these bills are nothing more than attempts to diminish the rights of women to control their reproductive lives.

Several other states have considered laws that would ban abortions sought for other reasons, specifically those sought on the basis of the race of the fetus or because of a diagnosis of genetic anomaly. Where the legislation includes a ban on "race-selective" abortions, it is clear that the supporters of the legislation are seeking to exploit civil rights language in order to limit access for women of color, forcing physicians to racially profile their patients in order to avoid the possibility of criminal penalties for providing needed health care. In the same way, bills that prohibit abortions sought when there is a diagnosis of a fetal condition are seeking to exploit the serious



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problems with discrimination against people with disabilities that exist in our society. When a woman receives this information about her pregnancy, it is important that she, her family, and her doctor have every medical option available to make a decision that is right for her and her family. These bills are not aimed at nor would they remedy the serious discrimination confronting people with disabilities or the obstacles confronting those who parent children with disabilities. The Center recognizes the importance of policies that have demonstrated effectiveness in combating inequality and remedying discrimination against people with disabilities in areas of health, employment, education, and public life. These bills would do nothing to further those goals—instead, they are callous and politically underhanded attempts to restrict access to reproductive health care. Restricting the grounds for legal abortion violates women’s rights and distracts from the government’s obligation to address the profound inequality and discrimination that exist in our society with respect to people with disabilities.

Reasons-based abortion bans are unconstitutional. A woman has the constitutional right to make her own decision about whether to choose adoption, end a pregnancy, or raise a child. Up until the point of viability, a woman may make that decision on her own or in consultation with whomever else she chooses; no woman need gain the approval of the state legislature for her particular reasons and her particular circumstances. The only state to pass such a law this year was North Dakota, which banned abortions sought on the basis of sex or because of a diagnosis of fetal impairment. Because this law violates women’s constitutional right to make their own decisions, the Center has filed a lawsuit in federal court seeking to strike the law down.

MEDICATION ABORTION RESTRICTIONS

Anti-abortion legislators targeted women’s access to medication abortion in 2013, proposing legislation in at least 10 states that would make it more difficult for women to access this early method of abortion care. Continuing the trend that began in 2010, a number of states have targeted rural women’s access to care by prohibiting the use of telemedicine in providing medication abortion. For rural and low-income individuals, telemedicine has become a critical delivery method for healthcare, enhancing the accessibility of quality care for many people in the United States. In the context of medication abortion, a rural patient is able to visit a local health clinic and be examined by an on-site healthcare professional, then talk with a physician working remotely who can review her health records, answer her questions, and provide the necessary medication. Thus far this year, four states—Alabama, Indiana, Louisiana, and Mississippi—have enacted proposals that will limit access to medication abortion, while others remain pending in Missouri, Texas and North Carolina.

RESTRICTIONS ON INSURANCE COVERAGE

In 2010, Congress enacted the Affordable Care Act (ACA), expanding access to healthcare for uninsured and underinsured people all over the country. Although the ACA has improved women’s access to health care in many significant ways, it has also allowed states to impose restrictions on women’s access to insurance coverage for abortion. Over the past three years, dozens of states have tried to pass laws banning insurance coverage of abortion in a variety of ways. These bills discriminate against women in the most fundamental way by restricting access to insurance coverage for health care that only women need. Moreover, they undermine the very purpose of insurance, which is to prepare for the unexpected.

So far in 2013, bills aimed at prohibiting insurance coverage have been enacted in five states and considered in more than 20 states. This year, Arkansas, Pennsylvania, and Virginia have

all passed legislation to ban coverage of abortion in their state health exchanges. Each bill contains only narrow exceptions for situations in which a woman's life is endangered or if the pregnancy is a result of rape or incest. Although women in Arkansas and Pennsylvania can theoretically purchase a separate rider for their insurance policies just to cover abortion, women in Virginia are prohibited from doing so. Moreover, research indicates that state laws permitting such riders do not guarantee that insurance companies will provide that option in the marketplace.

Kansas and Iowa also imposed new restrictions on insurance coverage for abortion. With an existing ban on private insurance for abortion except in individual insurance riders already in place, Kansas instead took aim at women's health savings accounts and imposed tax penalties on anyone who has purchased a separate rider providing insurance coverage for abortion or used health savings account funds to pay for abortion care. Iowa further restricted women's health coverage under Medicaid, enacting unprecedented legislation that requires the Governor to review billing for each Medicaid-eligible abortion to determine whether he believes that the abortion qualifies for insurance coverage under the limited exceptions permitted in the Medicaid program.

As of June, there are still seven states in session that are considering these harmful restrictions on insurance coverage of abortion.

TARGETED RESTRICTIONS OF ABORTION PROVIDERS (TRAP)

Anti-abortion legislators in at least 18 states have introduced bills that impose burdensome and medically inappropriate requirements on abortion providers. These bills, frequently referred to as targeted restrictions of abortion providers or "TRAP" laws, make it more difficult for women to exercise their constitutional right to choose abortion. Specifically, these types of laws make the delivery of healthcare services prohibitively expensive and in many cases place unnecessary restrictions on the qualifications of providers who perform abortions. Thus far in 2013, several states have passed TRAP legislation. North Dakota passed a bill that requires physicians to have admitting privileges at a local hospital with the clear intention of closing down the one remaining abortion clinic in the state. (*See page 10 for more information about this bill and the Center's litigation challenging it.*) There is no medical reason to require such privileges; no other physician who provides office-based surgery is required to have them. There are many reasons why some physicians, including some abortion providers, do not have such privileges. For example, abortion is one of the safest medical procedures available in the United States. Hospitals are often reluctant or unwilling to grant privileges to physicians who do not regularly admit patients to their hospital. Alabama, Louisiana, and Wisconsin also passed TRAP legislation this year, and similar bills are pending in several other states, including North Carolina and Texas.

STATE BY STATE: MOST EGREGIOUS RESTRICTIONS ON WOMEN'S ACCESS TO REPRODUCTIVE HEALTH CARE

ALABAMA

Alabama passed a TRAP bill with a number of burdensome provisions aimed at closing down many of the few remaining clinics in the state. Among the bill's medically unnecessary and politically motivated elements, HB 57 requires any healthcare provider who offers abortion care to do so in a facility that meets extensive facility and construction requirements—none of which are necessary for the safe provision of abortion services. The bill also requires that providers maintain admitting privileges at a local hospital. Further, HB 57 targets women's access to care by prohibiting the use of telemedicine to provide medication abortion. These restrictions are so clearly unnecessary and harmful that the ACLU and Planned Parenthood have brought a lawsuit challenging the law, which could have the effect of shuttering three of the five clinics in the state. In June, the federal district court granted the plaintiffs a temporary restraining order, finding that the law requiring admitting privileges was likely unconstitutional. [*Planned Parenthood Southeast, Inc., Reproductive Health Services, et al., v. Bentley et al.*]

ARKANSAS

Arkansas passed two of the most extreme abortion bans enacted since *Roe v. Wade*, as well as several other restrictions on abortion access.

The two bills—one banning abortion at 12 weeks and the other banning it at 20 weeks—were both vetoed by Arkansas Governor Mike Beebe, but both vetoes were overridden by the legislature. [Read the Center's veto [letters to Governor Beebe](#).] SB 134 bans abortion at 12 weeks of pregnancy with exceptions only for situations in which an abortion is necessary to save a woman's life, to prevent the risk of substantial and irreversible physical impairment of a major bodily function, or where the pregnancy is a result of rape or incest. In April, the Center, the ACLU, and ACLU of Arkansas filed a legal challenge against this unconstitutional abortion ban. [*Edwards v. Beck*.] On May 17, a federal judge issued a preliminary injunction against the law, thereby preventing it from going into effect while the legal challenge is ongoing.

The second bill, HB 1037, prohibits abortions after 20 weeks post-fertilization with narrow exceptions for situations in which an abortion is necessary to save a woman's life or to prevent the risk of substantial and irreversible physical impairment of a major bodily function. The law does not include an exception for mental health reasons and prohibits a physician from performing an abortion even if he or she believes there is a risk that the woman may commit suicide.

Arkansas also joined the growing number of states that prohibit insurance coverage for abortion in plans sold on the state health insurance exchange. HB 1100 permits insurers to offer coverage in cases when a woman's life is endangered or the pregnancy resulted from rape or incest. The bill permits optional abortion coverage outside of the exchange but subjects insurers to complicated

rules and procedures governing these riders, making it unlikely that insurers will actually offer them in the market.

HB 1447 includes a number of provisions related to minors, including a provision making it illegal to help a minor obtain an abortion without her parent's consent or notification. Most often, parents know when their daughters are facing an unintended pregnancy. Unfortunately, some young women have good reason to fear psychological and physical abuse and may rightly be concerned that telling their parents about a pregnancy or abortion would trigger such abuse. By preventing teens from seeking help from trusted adults, this law may simply make these difficult family situations more risky for teens.

INDIANA

Indiana was one of several states this year to pass legislation regulating medication abortion. SB 371 requires patients seeking medication abortion to have an ultrasound, prohibits physicians from providing medication abortion through telemedicine, and includes targeted restrictions on abortion providers, requiring some 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.

IOWA

Women who receive their insurance through Medicaid in Iowa are already prohibited from receiving coverage for abortions except in very narrow circumstances. Current Iowa law allows state funding of abortions through Medicaid in cases of rape, incest, or when the life of the mother is endangered, as is required by federal law, as well as in some cases where a diagnosis of a fetal anomaly has been made. SB 446 provides unprecedented discretion to the Governor of Iowa to review abortions on a case-by-case basis and determine whether they should be eligible for Medicaid reimbursement. The bill also requires that women have an opportunity to view an ultrasound and receive pregnancy-options counseling in order for the abortion to be eligible for coverage. Restricting public insurance coverage for abortion is discriminatory in any situation, but granting one person the right to determine whether her specific medical situation is eligible raises additional concerns: This goes further than politicians interfering with women's health care, this empowers one specific politician to make specific decisions about an individual woman's health care, and that is unconscionable.

KANSAS

Kansas legislators and Governor Sam Brownback once again exposed their callous disregard for women's health by enacting HB 2253, a bill that includes a laundry list of unconstitutional and harmful restrictions on healthcare providers and their patients. These changes to Kansas law would put women's health at risk, force physicians to give their patients false or misleading information, and impose discriminatory tax penalties on any health care provider or patient who provides or seeks abortion care. With some of its most appalling provisions:

- HB 2253 undercuts the "medical emergency" exception for all abortion regulations in Kansas in an incredibly dangerous way. Currently the medical emergency exception, which applies to each of the state's many abortion laws, allows physicians, including those in hospital emergency rooms, to immediately care for a patient in a medical emergency. HB 2253 significantly narrows the medical emergency exception so that almost no imaginable set of circumstances

would come within its purview.

- HB 2253 requires physicians to provide their patients with false information—including that abortion poses a risk of premature birth in future pregnancies, even though peer-reviewed scientific studies have concluded that this is untrue. The bill would also require physicians to tell patients that abortion poses a risk of breast cancer, even though the National Cancer Institute and others have repeatedly found that, based on a review of the best scientific studies, abortion does not increase the risk of breast cancer.
- HB 2253 imposes huge tax penalties on anyone who provides, seeks, or even carries insurance coverage for abortion services.
- HB 2253 creates a new “personhood” statement in Kansas law. Although subject to the protections of the United States and Kansas constitutions, this statement that “life begins at fertilization” raises the specter of a future where Kansans will not be able to access contraception, abortion, or fertility treatments, and where pregnant women in Kansas could face criminal investigations or prosecution after miscarriages.
- HB 2253 prohibits anyone who works for or volunteers with an organization that provides abortion care from providing any information on human sexuality to students in public schools.

The abortion-related provisions in this law are unconstitutional, pose a threat to women’s health and safety, and impose discriminatory policies on healthcare providers and their patients. For these reasons, the Center has filed suit in Kansas state court on behalf of two obstetrician-gynecologists who provide the full spectrum of reproductive health care to women, seeking to have the law struck down. *Hodes & Nausser MDs, P.A. v. Schmidt*. In late June, the court granted a temporary injunction against several provisions of the act, including the dangerous change to the medical emergency exception.

LOUISIANA

Louisiana was one of many states this year that sought to restrict access to abortion by enacting TRAP legislation. Although the scope of a particular medical specialty’s practice is determined by physicians, medical boards, and professional organizations, the Louisiana legislature nonetheless enacted SB 90, which permits only physicians who either have completed or are currently enrolled in a residency program for either family medicine or obstetrics and gynecology to provide abortions. The bill also prohibits the use of telemedicine for medication abortion.

MISSISSIPPI

Mississippi has a long track record of trying to restrict women’s access to reproductive health care. This year, in SB 2795, the Mississippi legislature and governor took aim at rural women’s access to care by prohibiting the provision of medication abortion through telemedicine.

MISSOURI

Missouri legislators chose to use the power of the state purse to support “crisis pregnancy centers,” organizations that advertise themselves as comprehensive reproductive health counseling centers but refuse to provide information about abortion or most forms of contraception. These centers frequently provide women seeking health care with intentionally misleading information, which can lead to delays in accessing care. SB 20 will give a major tax benefit to crisis centers in Missouri by allowing taxpayers to claim a tax credit for donations made to a pregnancy resource center. Further, Missouri legislators appropriated \$1.5 million in public funds to support such “alternatives to abortion services.”

MONTANA

In 2012, Montana voters approved a ballot measure that mandates parental notification before any minor under 16 can obtain an abortion. This proposal was initially passed by the Montana legislature and later vetoed by then-Governor Brian Schweitzer, in part because it is unconstitutional under the Montana Constitution. This year, the Montana legislature passed HB 391, mandating that before a minor under age 18 can have an abortion, a parent or legal guardian must sign a notarized form consenting to the minor’s abortion. Under HB 391, the minor can bypass parental consent only in a medical emergency, if the parent waives consent in a notarized written statement, or if the minor obtains a judicial bypass from a court. Although he is firmly pro-choice and opposes the legislation, Montana Governor Steve Bullock allowed it to take effect without his signature after deliberating with pro-choice allies in the state who have committed to litigate against this unconstitutional bill. As noted earlier, some young women have good reason to fear that telling their parents about a pregnancy or abortion would trigger physical or psychological abuse.

In late May, Planned Parenthood of Montana and Planned Parenthood Federation of America filed a lawsuit in state district court challenging both HB 391 and the parental notification law approved in 2012. *Planned Parenthood of Montana v. State*.

NORTH DAKOTA

This year, the North Dakota legislature targeted women’s access to abortion and other reproductive health care in an unprecedented way, passing not one but five unconstitutional and harmful bills that are intended to ban some or all abortions in the state. HB 1456, the earliest and most extreme abortion ban in the country, would make virtually all abortions in the state illegal after the point at which cardiac activity can be detected, beginning at about six weeks of pregnancy. The bill includes only the narrowest exceptions for life endangerment and serious risk of the substantial and irreversible impairment of a major bodily function.

North Dakota also enacted HB 1305, a law intended to police women’s reasons for seeking abortions. The bill would prohibit a provider from performing an abortion with the threat of criminal penalties if the physician believes that the patient is seeking the abortion because of a diagnosis of a genetic anomaly or because of the sex of the fetus. Although the bill purports to address discrimination on the basis of sex and disability, in reality it exploits these serious societal problems in order to diminish the rights of women to control their reproductive lives. (See the discussion of Reasons-Based Bans above.) Read CRR’s [letter](#) to Governor Jack Dalrymple in support of vetoing HB 1456 and 1305.

Both HB 1456 and HB 1305 clearly and directly violate the United States Constitution, which protects women's right to make the decision to terminate a pregnancy prior to viability. In June, the Center filed a lawsuit in federal court, challenging both unconstitutional abortion bans on behalf of the Red River Women's Clinic, which is the sole abortion provider in North Dakota. *MKB Management, Inc. v. Burdick*.

North Dakota also passed SB 2368, another unconstitutional law that prohibits abortions after 20 weeks post-fertilization with exceptions only for situations in which an abortion is necessary to save a woman's life or to prevent the risk of substantial and irreversible physical impairment of a major bodily function. The law excludes mental health from this exception and prohibits a physician from performing an abortion even if the physician believes there is a risk that the woman may commit suicide.

In addition to the outright bans, North Dakota passed two other abortion-related measures intended to eliminate abortion in the state. SB 2305 would require any physician who provides abortions in North Dakota to have admitting privileges at a local hospital. With only one clinic in the state and procedural hurdles at the few local hospitals that fall within the bill's scope, the legislature sought to use this bill to unconstitutionally eliminate abortion services in the state of North Dakota. Read CRR's veto [letter](#) to Governor Jack Dalrymple urging him to veto SB 2305. On May 15, the Center added a challenge to this law to an ongoing case in state court. *MKB Management Corp d/b/a Red River Women's Clinic, Tammi Kromenaker, Kathryn Eggleston, M.D., v. Birch Burdick and Terry Dwelle, M.D.*

Finally, the North Dakota legislature passed SCR 4009, which places a so-called personhood measure on the state ballot in 2014. If approved by North Dakota voters, this amendment could ban abortion, threaten access to some forms of birth control, and interfere with those who seek fertility treatments in order to form their families. This ballot measure violates the federal Constitution and seriously threatens the rights, life, and health of all North Dakota women.

OKLAHOMA

Not a year has gone by without the Oklahoma legislature considering multiple restrictions on abortion care, many of which have been struck down by courts over the years. In 2013, Oklahoma enacted five different laws directly aimed at limiting women's reproductive rights.

Oklahoma began and ended its session by targeting minors' access to reproductive healthcare. Oklahoma already has one of the most stringent laws restricting minors' access to abortion, requiring both parental consent and parental notification. Two of the new laws are intended to make it even harder for minors to access abortion care when they need it. The first, HB 1361, imposes new requirements on parents who have given permission to their minor daughters seeking abortions, requiring that the parent provide government-issued identification *and* present documented proof that he or she is the "lawful parent of the pregnant female." Parents already had to provide notarized consent, but now must initial each page of the permission statement. Further, although Oklahoma minors who feel they cannot involve their parents in their decision to seek an abortion have a constitutional right to petition a court to bypass parental involvement, this bill limits the courts to which minors may bring such petitions. By forcing minors who cannot involve their parents to go to local courts, this bill could put the privacy and even safety of minors, particularly those in rural areas, at risk.

Moreover, a second bill, HB 1588, changes the judicial bypass requirements to include even more onerous barriers. Under HB 1588, although a minor who feels she cannot involve her parent may petition a court to bypass the state requirement for parental *consent*, she is not able to bypass the requirement that her parent be *notified* unless she is being sexually or physically abused by her parent.

Then, in the last days of the session, Oklahoma passed HB 2226, which will require teens under 17 years of age to obtain a prescription in order to access Plan B One Step, a form of emergency contraception (EC), while allowing those 17 and older to obtain EC only from a pharmacy counter with photo-identification. This law was clearly in response to several recent advances in access to that particular form of emergency contraception, which has recently been approved by the FDA to be available over the counter to women of all ages without restriction. This decision by the FDA is consistent with all of the FDA's expert opinions and was also prompted by almost a decade of litigation and several clear court rulings ordering the FDA to take this action. Oklahoma's decision to put emergency contraception back behind the counter directly contradicts the FDA's order and will harm many women in the state. Putting the medicine behind the counter not only reduces access for teens but for any woman who does not have government-issued identification available when she needs to access this time-sensitive medication.

Oklahoma also amended its already extensive, intrusive law requiring physicians to document and report dozens of pieces of information about their abortion patients. HB 2015 will require physicians to print out each patient's ultrasound image, redact the patient name, and then submit the picture to the state Department of Health. This bill serves no purpose whatsoever, other than to intrude on patients' privacy by making their personal medical information property of the state. The bill also threatens physicians with the potential for myriad frivolous lawsuits by allowing a group of any 10 Oklahoma voters to bring an action against any physician for alleged violation of the statute, even if the state Department of Health has not found a violation.

Finally, Oklahoma took steps to prevent Planned Parenthood from accessing family planning and counseling funding by restructuring the way that the state awards state and federal funds. This new policy could impact women's ability to access comprehensive reproductive health care from qualified providers and is clearly motivated by opposition to Planned Parenthood.

PENNSYLVANIA

Pennsylvania joined the growing number of states that restrict women's access to insurance coverage for abortion. HB 818 prohibits insurance plans offered through the state health exchange from covering abortion services unless the pregnancy is the result of rape or incest or the life of the mother is endangered.

SOUTH DAKOTA

In 2011, South Dakota became the first state—and is still one of only two—to impose an extraordinarily long waiting period on all women seeking abortions, requiring women to wait 72 hours after their first visit to a physician's office before being permitted to obtain an abortion. Moreover, the 2011 law required each woman seeking an abortion to visit a crisis pregnancy center in the intervening days and to provide proof that she had obtained counseling at one of

these anti-abortion organizations. This year, South Dakota enacted HB 1237, which amends the waiting period law to exclude Saturdays, Sundays, and annual holidays from the 72-hour waiting period. Although the purpose of waiting period laws is ostensibly to provide the woman with time to reflect upon her decision to have an abortion, obviously a woman does not cease to reflect simply because it is the weekend or a holiday. Extending the waiting period in this way was clearly intended to further delay women seeking medical care and could increase risks to some women's health. The waiting period in South Dakota could stretch as long as a week or more, particularly for women who are experiencing domestic violence, as pregnancy is a particularly dangerous time in an abusive relationship. The logistics associated with two trips to a clinic often increase the risk that the abuser will attempt to thwart the woman's ability to obtain care.

The ACLU and Planned Parenthood challenged the original law in 2011, and the requirement that a woman seek counseling at a crisis pregnancy center has been preliminarily enjoined by a federal court as the litigation continues. *Planned Parenthood Minnesota, North Dakota, South Dakota v. Daugaard*.

WISCONSIN

The Wisconsin legislature has enacted legislation designed to shame and demean women who have made the decision to terminate a pregnancy. Wisconsin Governor Rick Synder has vowed to sign the bill when it reaches his desk, which is expected to happen in early July. SB 206 requires every patient seeking an abortion to be shown an ultrasound image, to listen to a detailed description of that image, and to listen to the fetal heart tone a full 24 hours before she is permitted to have an abortion. There are just a few narrow exceptions for some victims of sexual assault and incest, and for extremely dire health situations. These requirements are intrusive, interfere in the doctor-patient relationship, patronize women, and violate the constitutional rights of both patients and providers. Moreover, requiring women to make multiple trips to a healthcare provider before obtaining an abortion imposes significant burdens, especially on low-income women who need child care or who lack transportation. These types of laws also impose onerous burdens on women who are experiencing domestic violence because pregnancy is a particularly dangerous time in an abusive relationship. Further, SB 206 also requires abortion providers to maintain admitting privileges at a local hospital, which, as noted earlier, is unnecessary, burdensome and intended to limit access to care.

VIRGINIA

Virginia enacted HB 1900, banning insurance coverage of abortions in the state health exchange. The bill only contains narrow exceptions for insurance coverage if a woman's life is endangered or if the pregnancy is the result of rape or incest.

CONCLUSION

In at least 15 states, legislation designed to restrict women's access to reproductive healthcare and impinge on their constitutional rights has already become law. However, state advocates and legislators have also proposed proactive measures throughout the country that would strengthen protections for reproductive rights and increase access to reproductive health care. As the year continues, and more restrictive bills are considered, pro-choice advocates and legislators will continue to fight against the passage of these harmful laws in their own states and to advocate for the passage of positive measures that would help women and families rather than harm them.

Over the next six months, the Center for Reproductive Rights will continue to analyze the impact of this year's legislation and to work with advocates and legislators to oppose similar legislation.

For more information on individual states' new laws and state legislative activity across the country, please contact **Jordan Goldberg**, State Advocacy Counsel, at jgoldberg@reprorights.org. For press inquiries, please contact **Kate Bernyk**, at kbernyk@reprorights.org.