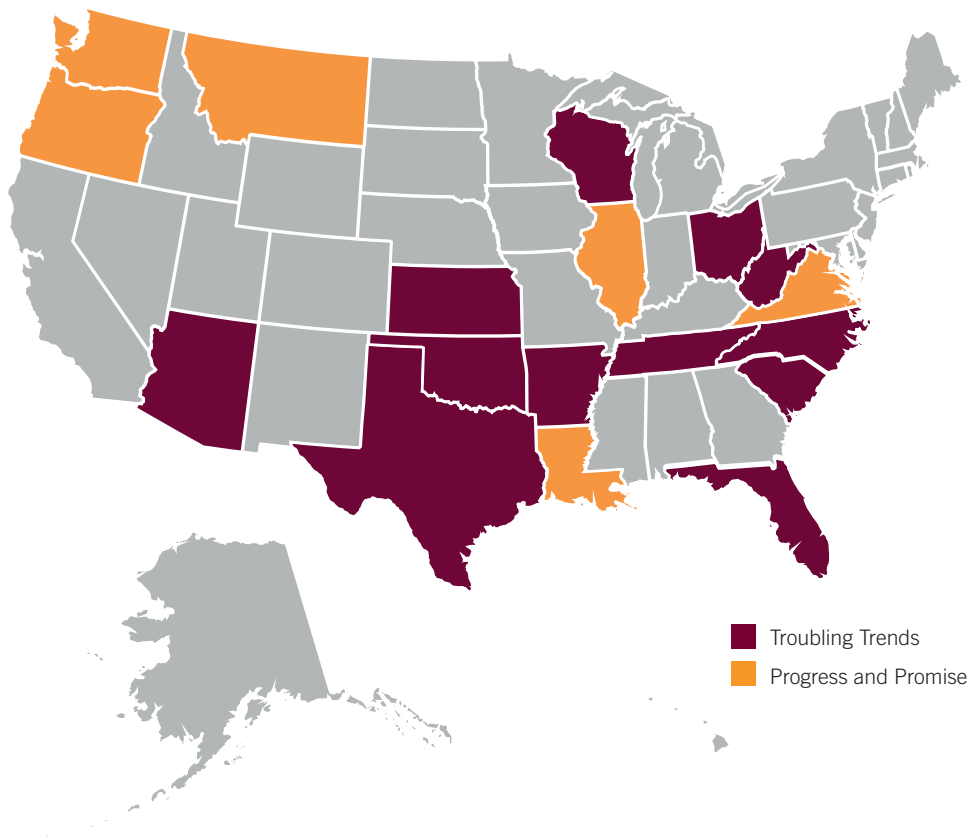


THE STATE OF THE STATES: 2015 AT THE MIDPOINT



Troubling trends abound, but some bright spots provide hope for the future of reproductive health care access. This year saw the continuation of harmful trends in state legislatures to restrict reproductive rights and access, either through sham laws that force clinics to close their doors for medically unnecessary reasons or through efforts to interfere with women’s decision-making abilities. New attempts to restrict abortion—relying on junk science and outrageous claims—appeared in state legislatures and may set the stage for future trends. Meanwhile, the legal outcomes of multiple state abortion restrictions remain unclear as cases wind their way through the courts.

But reasons for optimism in our movement to change the landscape of state reproductive rights and access also continue. New resources and partnerships are percolating to shift our culture to one of proactive, forward-thinking action. While we track hundreds of state bills regarding reproductive health and rights, here are some key developments at the 2015 midpoint.

TRUUBLING TRENDS

1. **Anti-choice politicians play doctor at the expense of women’s health and autonomy**
2. **Southern states erect new barriers designed to delay and obstruct women seeking abortion care**
3. **Tennessee ballot initiative opens the floodgates to restrictions**
4. **Arkansas enacts six different bills attacking access to reproductive health services from all angles**
5. **Texas attacks teens, undocumented women, and low-income women**
6. **Abortion bans designed to test the boundaries of *Roe* continue**

PROGRESS AND PROMISE

1. **The movement to restore full insurance coverage for abortion continues**
2. **Virginia attorney general stands up for women's health**
3. **Montana governor Steve Bullock strikes out the Montana legislature and protects access to safe, legal abortion care**
4. **First-of-its-kind anti-choice, anti-Asian American bill defeated in Louisiana**
5. **Research and resources for advocates and policymakers**

TROUBLING TRENDS

1. Anti-choice politicians play doctor at the expense of women's health and autonomy

Anti-choice politicians entered uncharted territory this session, enacting unprecedented threats to the patient-provider relationship that amount to experimentation on women seeking abortion. Four states enacted first-ever laws that require abortion providers to cast aside their medical judgment and expertise in favor of extreme political agendas aimed at decimating women's reproductive choices.

Arizona and **Arkansas** enacted new biased counseling measures (Arizona SB 1318 and Arkansas HB 1394) that require health care providers to inform patients that medication abortion may be "reversed." This statement is based on junk science and motivated by nothing more than the desire of anti-abortion extremists to control women's reproductive choices. By forcing health care providers to give patients unscientific, unsubstantiated information, this new requirement is bad medicine at its worst.

In June, the Center for Reproductive Rights, along with the ACLU and Planned Parenthood Federation of America, challenged the Arizona law in federal court. We argued that the law forces doctors to lie to their patients in violation of the First Amendment, and violates patients' constitutional right to choose abortion because it requires them to receive untruthful, misleading, and irrelevant information prior to obtaining care. In June, the court blocked enforcement of the law until a hearing can be held later this year.

A coalition of 16 organizations which oppose inappropriate interference in the patient-health care provider relationship, including the American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians, and the National Physicians Alliance, [criticized these bills](#) because they "requir[e] health care professionals to violate their medical training and ethical obligation to their patients." Separately, ACOG—the nation's leading group of physicians providing health care for women—[noted](#) "claims of medication abortion reversal are not supported by the body of scientific evidence, and this approach is not recommended in [our] clinical guidance on medication abortion."

Kansas and **Oklahoma** enacted a pair of similar, troubling bills that criminalize physicians who provide services to women seeking safe and legal abortion care. Kansas SB 95 and Oklahoma HB 1721 each ban a safe, effective, medically proven, and most commonly used method of ending a pregnancy in the second trimester. These laws could force some women to undergo an additional, invasive, unnecessary medical procedure, even against the judgment of her

physician. They represent an unprecedented attack on women's health, personal autonomy, and the doctor-patient relationship.

In passing the bill, the Kansas legislature ignored the objections of local and national medical experts, including over 20 area physicians. In June, [the Center challenged the Kansas law in state court](#), arguing that the ban violates women's rights to abortion and bodily integrity under the Kansas constitution, and that the law places physicians in the untenable position of choosing between the standard of care they believe is best for their patients and facing criminal prosecution. On June 25, the court granted the plaintiffs' request for an injunction, temporarily blocking the law.

2. Southern states erect new barriers designed to delay and obstruct women seeking abortion care

This session brought a slew of new harmful and demeaning restrictions on women's access to abortion care in the South. Nationally, state legislators proposed more than 20 bills in 16 states this year that would create or worsen an existing waiting period—laws that force a woman to wait between receiving state-mandated biased counseling and obtaining the abortion.

Five of these bills became law in the South, in **Arkansas, North Carolina, Oklahoma, Tennessee,** and **Florida**. Three of those laws require the patient to make two separate trips to her health care provider in order to obtain care.

Many new laws from 2015 force women to wait 48 or even 72 hours before obtaining care. Arkansas HB 1578 doubles the amount of time the state forces a woman to wait and requires patients to make two separate trips before obtaining abortion services. Oklahoma HB 1409 and North Carolina HB 465 both triple the state's existing waiting period, joining only three other states in the nation to force patients wait 72 hours before they can receive care. Florida (HB 633) and Tennessee (SB 1222), the only two Southern states before 2015 that did not have a state-mandated waiting period, now require patients to make two trips and wait 24 and 48 hours, respectively. Absent a court order blocking enforcement of the law, *now every single state* in the South forces a woman to delay obtaining abortion care.

Not only are [state-mandated waiting periods harmful](#), they can jeopardize the health of women seeking abortions. Preventing or delaying access to reproductive health care can result in increased health risks associated with continuing pregnancies and later abortion procedures. Moreover, the burdens associated with requiring patients to make two trips fall the hardest on low-income women, women who live in rural areas, and women in abusive relationships. Multiple tanks of gas, overnight hotel stays, time off from work, and child care arrangements can amount to a financial or logistical impossibility.

In other cases, these laws threaten the safety of women who face the threat of abuse at home. By requiring two trips, some of these laws could make it twice as likely that a woman's abuser will discover her plans. Burdens such as these can make it impossible for some women to obtain necessary abortions, or can cause women to delay their abortions.

Following legal action, women in Florida have been granted temporary reprieve from mandatory delays. In June, [the Center and the ACLU challenged the Florida 24-hour waiting period law in state court](#), arguing it violates the state constitution's strong privacy protections. On June 30, a state court temporarily blocked the law while the case proceeds.

3. Tennessee ballot initiative opens the floodgates to restrictions

In November 2014, **Tennessee** voters narrowly approved a [constitutional amendment](#) designed to strip state constitutional protections for reproductive rights and allow state policymakers to “enact, amend, or repeal statutes regarding abortion.” In January, the Tennessee legislature quickly got to work restricting access to safe and legal abortion, introducing 12 anti-choice bills and passing two into law. Gov. Bill Haslam signed both bills less than six months after the amendment took effect.

The loss of longstanding protections for reproductive rights opened the floodgates for lawmakers to introduce and pass politically motivated measures. The laws enacted affect women throughout the South who had previously relied on Tennessee clinics to receive essential reproductive health care [scarcely available in the region](#). The first, SB 1280, threatens to shutter clinics by requiring facilities that perform more than 50 surgical abortions per year to be licensed as ambulatory surgical centers. The American Congress of Obstetricians and Gynecologists [deems](#) these types of onerous clinic shutdown laws medically unnecessary. A similar, now-infamous 2013 restriction would have shuttered clinics across the state of Texas. On June 29, the U.S. Supreme Court blocked that provision while Texas health care providers request a review of the case by the nation’s highest court.

Governor Haslam signed HB 977, a law mandating that a woman attend an in-person biased counseling session and wait 48 hours before receiving abortion care. This additional trip requirement can increase associated costs of travel, accommodations, and child care, making it all the more difficult for a woman to have the abortion she has determined is best for her and her family. In June, the Center challenged both SB 1280 and HB 977 in federal court, in addition to a 2012 clinic shutdown law that requires all doctors providing abortion care in the state to obtain admitting privileges at a local hospital. On June 26, the court blocked SB 1280 from taking effect, allowing two of the state’s remaining six abortion clinics that provide surgical care to remain open while the case proceeds.

The good news is that following the rejection of anti-choice ballot measures in **Colorado** and **North Dakota** in 2014, state lawmakers pulled back on passing new restrictions in 2015. After Coloradans rejected an attempt to ban abortion in the state by ballot measure for a third time, seven anti-choice bills failed to pass in the legislature.

Following a 2013 session during which North Dakota legislators passed some of the most extreme restrictions on reproductive rights in the country, the state’s electorate in 2014 resoundingly voted down a legislatively referred constitutional amendment that severely threatened a range of essential services in the state – and no abortion restrictions passed in North Dakota in 2015. These victories demonstrate the need for continued diligence in standing up to attacks on reproductive rights, whether in the capitol or on the ballot.

4. Arkansas enacts six different bills attacking access to reproductive health services from all angles

The Arkansas legislature unleashed an all-out assault on access this session, forcing health care providers to inform patients that medication abortion may be “reversed” and requiring physicians to provide false information based on junk science to their patients. Moreover, the state:

- doubled their waiting period to 48 hours and now forces women to make two separate trips to a provider in order to obtain an abortion,
- passed two different laws banning abortion via telemedicine,
- passed a bill requiring physicians to adhere to an outdated, less effective, and more expensive protocol for providing medication abortion,
- created more onerous requirements for teens who cannot involve their parents in their decision to have an abortion, and
- defunded Planned Parenthood.

This onslaught represents the highest number of new anti-abortion laws enacted by a state this year. It further burdens women seeking abortions, particularly low-income women, in what is the second-poorest state in the country and the [second-worst state for women’s and children’s health and well-being](#).

5. Texas attacks teens, undocumented women, and low-income women

Just two years after omnibus anti-abortion law HB 2 passed, now leaving [all but nine clinics in the state at risk of being closed](#), Texas continued to chip away at abortion access across the state. [Signed into law by Texas governor Greg Abbott](#) on June 12, 2015, HB 3994 is another omnibus measure, this time explicitly targeting minors, undocumented women, and low-income women.

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

HB 3994 will also decimate abortion access [for abused and neglected Texas teens](#). The U.S. Supreme Court has long held that the federal Constitution permits states to require a minor to involve a parent before obtaining an abortion, so long as the state also provides an alternative means by which she can seek authorization. This alternative usually takes the form of a judicial bypass procedure, a court proceeding in which the minor asks a court’s permission to obtain an abortion without involving her parents. The Court has held time and time again that this hearing must be confidential, expeditious, and provide the teen with an “effective opportunity” to obtain the desired abortion.

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

Along with more than 30 other reproductive health-related restrictions, Texas this year also attempted to pass SB 575, a wide-reaching ban on insurance coverage for abortion. This bill would have prohibited all insurers in the state from providing abortion coverage, with exceptions only for a medical emergency or where abortion coverage is provided separately from other health benefit plan coverage.

Restrictions on coverage not only interfere with a woman's ability to make personal decisions, but also disproportionately harm women who already face barriers to accessing health care, including low-income women and women of color. SB 575 failed to pass this session, but advocates are prepared to defeat future attacks on coverage for all reproductive health services, including abortion, next session.

6. Abortion bans designed to test the boundaries of *Roe* continue

Both **West Virginia** and **South Carolina** spent the 2014 legislative session trying to pass unconstitutional pre-viability 20-week abortion bans, but they failed due to legislative deadlines and a veto by West Virginia governor Ray Tomblin. However, in 2015, West Virginia had enough votes to override Gov. Tomblin's veto, and passed a cruel and dangerous 20-week ban into law.

HB 2568 prohibits physicians from offering abortion care after 20 weeks of pregnancy – providing no exceptions for rape or incest survivors and only an extremely narrow exception for medical emergencies and lethal fetal anomalies. The very few West Virginia women who may need to seek abortion services after 20 weeks already face extreme barriers to care, as there are only two clinics providing abortion services in the entire state. While some state legislatures defeated 20-week bans this session, as of this writing, **Wisconsin** and **Ohio** are poised to approve this unconstitutional and cruel legislation. In good news, the South Carolina legislature once again failed to pass a 20-week ban before the end of the legislative session, despite different versions of a 20-week ban passing in both the House and Senate.

Meanwhile, the legal challenge led by the Center for Reproductive Rights and the ACLU against a March 2013 Arkansas law aiming to ban abortion at only 12 weeks of pregnancy continues, and, in May 2015, a panel of the U.S. Court of Appeals for the Eighth Circuit ruled that the law is unconstitutional, keeping in place the permanent injunction issued by the lower court. On July 9, the full Eighth Circuit denied Arkansas' request to review the law, permanently blocking the ban from taking effect.

The state of Arkansas can appeal this decision to the Supreme Court. However, the Supreme Court recently refused to review a decision permanently blocking Arizona's ban on abortion at 20 weeks, and courts in Idaho and Georgia have also blocked similar pre-viability bans. The constitutional standards are very clear that these types of laws cannot stand.

PROGRESS AND PROMISE

1. The movement to restore full insurance coverage for abortion continues

Not content with just playing defense to protect existing insurance coverage for a full range of reproductive health services, advocates and lawmakers throughout the country in 2015 took continued steps to restore coverage for abortion care no matter where a woman gets her insurance.

In **Oregon**, the Comprehensive Women's Health Bill (SB 894) would require all insurance providers to cover contraceptives (including allowing for a full year's worth of birth control at a time), abortion, pre- and postnatal care, and breastfeeding assistance services. Advocates advanced a community-based strategy to complement the state policy strategy. The Western States Center released the [We Are Brave Toolkit](#) to help organizations champion abortion coverage. NARAL Pro-Choice Oregon and others led [a lobby day in the capital](#).

Washington State's Reproductive Health Act was a key part of the Washington Women's Health Agenda developed by advocates. The act would have required that all health plans that cover maternity care include abortion care.

In **Illinois**, lawmakers advanced HB 4013 to remove decades-old provisions in state law that ban coverage for abortion care in the medical assistance program and for state employees.

Meanwhile, in Madison, WI, [local elected officials joined a growing chorus](#) of local actions in support of restoring and protecting insurance coverage of abortion. Advocates in these states and beyond tapped into the energy of the [All* Above All](#) movement to restore insurance coverage for abortion care.

2. Virginia Attorney General stands up for women's health

Between 2011 and 2013—caving to extreme political pressure and scare tactics from the former **Virginia** governor and attorney general—the Virginia Board of Health promulgated regulations that required abortion providers to meet excessive building standards that threatened to close clinics across the state. These regulations were contrary to the board's own advisory panel recommendations; the burdensome construction standards would do nothing to advance women's health and would impede access to care for many Virginians.

In May, Virginia Attorney General Mark Herring took the first critical steps to ensure women's access to safe, legal, and high-quality reproductive health care providers. A [legal opinion issued by his office](#) calls for existing health care facilities offering abortion services to be exempt from meeting the onerous and medically unnecessary construction standards. It advises that abortion providers be treated the same as every other similarly regulated health care facility by allowing them to continue to provide care in their current facilities.

The opinion “revokes and overrules” the flawed advice given to the Board between 2011 and 2013 by former attorney general Ken Cuccinelli, who threatened the Board with legal action if they attempted to “grandfather in” existing clinics. It represents a crucial step toward safeguarding women's access to abortion care providers in Virginia, and demonstrates policymaking that is truly based on sound medical evidence, not politics.

3. Montana governor Steve Bullock strikes out the Montana legislature and protects access to safe, legal abortion care

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

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

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

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

4. First-of-its-kind anti-choice, anti-Asian American bill defeated in Louisiana

Anti-choice politicians in **Louisiana** introduced HB 701 this year, an unprecedented measure that would have forced abortion patients to learn the sex of their fetus and ban abortions based on the sex of the fetus. This bill's clear intent was to intimidate and shame women seeking abortion care.

By banning so-called "sex selective abortions," this bill was nothing more than a cynical attempt to choke off access to reproductive health care services while doing nothing to combat the real and deeply rooted problems that lead to gender-based discrimination and son preference. Moreover, they target communities of color, particularly Asian Pacific Islander (API) communities, and are fueled by stereotypes that API families do not value girls.

The [National Asian Pacific American Women's Forum](#) (NAPAWF), the only national, multi-issue organization for API women and girls in the United States, opposes sex selection bans like HB 701 because they do not remedy the core problem of discrimination against women and girls. The legislature backed down after testimony from NAPAWF and allied organizations exposed the bill for what it was: a solution in search of a problem and a demeaning attack on API women and girls.

5. Proactive priorities: Research and resources for advocates and policymakers

Year after year, anti-choice policymakers spend their time and energy introducing and passing new restrictions on abortion—all in the name of supporting women's and children's health and safety. Our report with Ibis Reproductive Health, [Evaluating Priorities: Measuring Women and Children's Health and Well-being against Abortion Restrictions in the States](#), explored these claims and found that the states with the most restrictions on abortion have in fact done the least to implement evidence-based policies that are known to support women and children's health and well-being.

This report also found that the states with the most abortion restrictions tend to have the poorest outcomes in women's, children's, and social determinants of health. During the 2015 legislative session, advocates across the country applied the Evaluating Priorities findings in their education, policy, and outreach work. They called on state legislators to "check your priorities" and shift focus to policies that truly improve the lives of women and families.

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

Building off this groundbreaking resource, the Center recently held a first-of-its-kind convening for state lawmakers and advocates focused on building a proactive state agenda. The [State Leadership Summit: A Proactive Vision for Reproductive Health and Rights](#) will kick off a network of committed legislators and advocates advancing innovative state policies in support of reproductive health, rights, and justice.

While there is a need for improvement everywhere, there are parts of the country where a lack of access to reproductive health care hits certain communities especially hard. [Nuestro Texas](#), the groundbreaking human rights campaign led by the Center for Reproductive Rights and the National Latina Institute for Reproductive Health, released a proactive policy blueprint in February 2015, prior to the 84th Texas legislative session. [Nuestro Texas: A Reproductive Justice Agenda for Latinas](#) provides concrete policy recommendations to affirm reproductive rights as human rights, reflecting Latinas' demands for a better Texas.

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