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CHIPPING AWAY AT CHOICE:

Growing Threats to Women's Health Care Access and Autonomy: 2015 Update



In 2013, our *Chipping Away at Choice* report outlined five growing threats to reproductive health care access: targeted regulation of abortion provider (TRAP) laws, crisis pregnancy centers, mandatory waiting periods, race- and sex-selective abortion restrictions, and interference with medical providers. These restrictions, often presented as commonsense measures to protect women's health, are, in actuality, part of a concerted effort by the anti-choice movement to quietly chip away at reproductive health access and undermine the foundation of long-standing rights.

Sadly, these damaging, incremental tactics have become even more widespread since our last report, driven by conservative gains in the 2014 elections and the continued state-level advocacy of anti-choice groups including Americans United for Life and the National Right to Life Committee. States have enacted a staggering 282 new abortion restrictions since 2010, according to statistics compiled by the Guttmacher Institute. Fifty-one of those new restrictions were enacted in the first half of 2015 alone.



Americans United for Life's (AUL) general counsel reportedly once compared his group's approach to ending legal abortion to carving a ham: "Each slice makes it smaller and smaller until it is no more."

This strategy of abolishing legal abortion in incremental steps faces a critical legal test as the Supreme Court decides whether to consider

an appeal of a lower court decision upholding sweeping restrictions on abortion clinics in Texas. If the law is allowed to stand, all but a few of the state's abortion providers could be forced to close, and the anti-choice movement's "chipping away at choice" strategy would achieve one of its biggest victories yet.

The quieter, incremental tactics of anti-choice activists create barriers to abortion access in an attempt to force more women to carry unwanted

pregnancies to term. Such burdens, such as high costs exacerbated by mandatory waiting periods and the need to travel long distances to reach increasingly scarce providers, disproportionately impact low-income women. In this way, it is often the women whose financial stability and future success hinges on abortion access that are the very women who are denied reproductive care.

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In this updated report, we examine recent developments in these incremental anti-choice efforts and explore an additional incremental threat to abortion access and reproductive care: 20-week abortion bans.

We also look at the influence of a segment of the anti-choice movement that rejects these incremental strategies and instead advocates for more openly radical policies meant to present a direct challenge to *Roe v. Wade*. The "personhood" movement seeks to grant full legal rights to human embryos from the moment of fertilization. Heartbeat bills, such as a North Dakota measure that was struck down by a federal court in 2015, seek to ban abortions after the point at which a heartbeat can be detected by ultrasound, as early as six weeks into a pregnancy. These measures often receive more public attention than their more incremental counterparts, despite the fact that both strategies have the same radical end goal: to end legal abortion in America.

More than half of U.S. women of reproductive age now live in states that Guttmacher labels "hostile" or "extremely hostile" to abortion rights, compared to fewer than one-third of women in 2000. While radical, head-on attacks on abortion rights capture the public's attention, conservative legislators and anti-choice groups continue to work tirelessly to quietly whittle away at women's access to safe and legal abortion.

DEFUNDING WOMEN'S HEALTH CARE PROVIDERS

Anti-choice legislators are increasingly using the abortion issue to attack other women's health services, especially those provided by Planned Parenthood. While Planned Parenthood receives federal funding for health services such as contraception, cancer screenings and STI testing, no federal funding is used for abortion services, in compliance with the Hyde Amendment.

In a continuing smear campaign against Planned Parenthood, anti-abortion propagandists at the Center for Medical Progress have created misleadingly edited videos that falsely claim to show Planned Parenthood employees discussing the sale of fetal body parts. The manipulated footage, which is part of a long history of videos doctored to support an anti-choice agenda, has reignited a disinformation campaign against the women's health care provider in Congress, where Sen. Rand Paul of Kentucky is currently spearheading a campaign to end all funding to it. Anti-choice groups have organized rallies across the country demanding that states pull funding from the organization, and Sen. Ted Cruz is working with a well-funded Christian nationalist pastors' network to do the same. Although at least 11 states have launched investigations into Planned Parenthood's practices, every investigation concluded as of the writing of this report has cleared the organization of wrongdoing.

The Center for Medical Progress' campaign,

nevertheless, has reignited the anti-choice movement's long-term goal to eliminate funding for Planned Parenthood's services to low-income women, with the ultimate goal of collapsing the organization. Because the federal government and many states bar the use of taxpayer dollars to pay for abortions, pulling taxpayer money from Planned Parenthood in effect hampers the ability of the organization to provide affordable preventative care to low-income women.

Seven states currently bar family planning funds from going to organizations that provide abortion services, laws that proponents often boast are aimed directly at Planned Parenthood. Since the latest wave of attacks on Planned Parenthood began, five states have attempted to prevent Medicaid funds from going to Planned Parenthood clinics, which the federal government has warned is in some cases a violation of federal law.

Planned Parenthood's critics argue that if the organization's funding is cut, other health care providers will be able to fill the void that is left. The experience of states that have successfully defunded Planned Parenthood, however, suggests otherwise. When Texas ended its Planned Parenthood funding, nearly 200,000 women — disproportionately women with low incomes and living in rural areas — were put at risk of losing critical preventative care. In a survey of pregnant women one year after the budget cuts, nearly half of the women surveyed reported being unable



to access birth control they wanted to use in the three months before they became pregnant due to the cost of care and the closure of nearby clinics. A nationwide defunding of Planned Parenthood would be catastrophic, resulting in higher numbers of unintended pregnancies and, consequently, higher costs for the government to bear due to increased health costs for low-income women on government assistance programs.

Anti-choice activists and House Republicans are also targeting the Title X family planning program, a federal grant program that provides affordable contraceptives and other preventative health services to the low income and uninsured. In a move that would eradicate coverage for 4.6 million Americans, the House Appropriations Labor-HHS Subcommittee released a 2016 budget proposal that zeros out funding to the Title X program as well as cutting funding to sex education programs for teenagers by 81 percent.



History: Women and ‘Undue Burdens’

Prior to *Roe v. Wade*, the 1973 Supreme Court decision that established women’s constitutional right to abortion, illegal abortions were common, leading to thousands of hospitalizations and hundreds of deaths each year, with low-income women suffering disproportionately from the health consequences. Data from the World Health Organization illustrates that this trend still exists in nations that restrict abortion access today, with 47,000 deaths each year associated with unsafe abortions.

In *Roe v. Wade*, the Supreme Court guaranteed the right to an abortion in the first two trimesters of pregnancy. While prohibiting government interference with a woman’s right to an elective abortion in the first trimester, the Court allowed states, starting in the second trimester, to regulate abortion only in “ways that are reasonably related to maternal health.” In 1992’s *Planned Parenthood v. Casey*, the Court narrowly rejected an attempt to overturn *Roe*, but gave states greater leeway to regulate the procedure. As summarized by the American Prospect, *Casey* “made viability [of the fetus] the point at which the states could prohibit abortion, and it allowed

restrictions on abortion rights as long as they didn’t place an undue burden on the mother.”

Although the anti-choice movement was disappointed that the Court failed to overturn *Roe*, it saw an opportunity in *Casey*, embarking on a decades-long campaign to weaken the “undue burden” standard and undermine *Roe*’s protections. While parts of the anti-choice movement continued to loudly campaign for a total and immediate prohibition on legal abortion, the most influential anti-choice have groups embraced a quieter, more incremental strategy in pursuit of the same goal.

Far from being an organic effort by state legislators to make abortion safe for women, these laws are driven by large, well-funded anti-choice groups including Americans United for Life and the National Right to Life Committee, which provide model bills for legislators and make no secret about their ultimate goal of ending legal abortion.

In the following section, we outline seven quiet threats to choice, and the resulting burdens that they create.

Quiet Threats to Choice

TRAP Laws: The Trojan Horse of the Anti-Choice Movement

Targeted regulation of abortion providers (TRAP) laws, one of the most common methods used by state legislatures to restrict reproductive health care access, subject clinics and doctors to burdensome and unnecessary restrictions in an attempt to force clinics to close.

Sold as regulations necessary to protect women's health, TRAP laws often evade scrutiny and are frequently passed without significant opposition. Legislators sell these laws by giving them names such as Arkansas' "Abortion Patients' Enhanced Safety Act" (based, it seems, on an Americans United for Life model bill of the same name), and claiming that they are necessary for women's safety. However, far from protecting health and safety, TRAP laws cut off women's access not only to abortion services, but to contraceptives, cancer screenings, STI testing, and other vital health care services. These regulations have gone so far as to regulate the size of a janitor's closet and the height of the grass outside the clinic.

According to Guttmacher, 24 states currently "have laws or policies that regulate abortion providers and go beyond what is necessary to ensure patient safety." In 17 of these states, the same regulations apply to clinics that only offer medication abortions.

Some TRAP laws take the form of building regulations that require clinics to perform costly and unnecessary renovations. Currently, 22 states impose "onerous licensing standards" on abortion clinics, including 11 states that specify the size of procedure rooms, 11 states that specify corridor width, and 11 states that require abortion facilities to be within a certain distance from a hospital. A Texas TRAP law, passed in 2013 and currently working its way through judicial appeals, would require abortion providers to adhere to the same standards as surgical clinics, as well as requiring providers to have unnecessary hospital admitting privileges, threatening to close all but a handful of clinics in the state.

First-trimester abortion is one of the safest medical procedures, with less than 0.05 percent resulting in complications that might

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need hospital care. Less than 0.3 percent of all abortion patients in the United States experience a complication that requires hospitalization. The proven safety of abortion procedures delegitimizes requirements that force abortion facilities to meet the burdensome and costly standards of ambulatory surgical clinics.

Another type of TRAP law, a variety of which is currently on the books in 13 states, requires doctors who perform abortions to have admitting privileges at a local hospital. This requirement is often impossible to meet, especially for abortion clinics that rely on out-of-state doctors for abortion services. Admitting privilege laws, like building regulations, are billed as necessary to protect women's health. However, abortion patients who suffer complications already can be, and are, admitted to hospitals even when providers do not have admitting privileges.

In 2014, Louisiana Gov. Bobby Jindal signed an admitting privileges law, knowing that five of the six abortion providers in the state would be unable to meet the law's stringent requirements. The administrator of a clinic in Shreveport testified that if the law is enforced, her clinic will be forced to close, despite the fact that both of its doctors have agreements with local hospitals to take patients in emergencies. A similar law signed by Ohio Gov. John Kasich in 2013 has forced five abortion providers in the state to close. Admitting privilege requirements have been struck down by courts in Wisconsin, Mississippi, and Alabama. In August 2014, a federal judge issued an injunction to block Louisiana's admitting privileges law from taking effect.



Because TRAP laws are often embedded within complicated legislation and involve seemingly reasonable or innocuous regulation, they can fail to attract attention from the public. This allows legislators to pass these harmful laws without meaningful opposition or debate. In addition to casting TRAP laws as beneficial for women's health, anti-choice lawmakers have employed a deceptive strategy of loading TRAP legislation with more controversial provisions. The contested portions of the bill are later dropped, so that conservative lawmakers can make a show of compromising, even while they achieve their ultimate goal of passing TRAP laws. For example, in January 2013, Indiana legislators introduced a bill that would have required two transvaginal ultrasounds before a woman could be given RU-486 for a medical abortion, and included various TRAP provisions. In response to considerable public protest, the ultrasound provisions were later dropped. However, the TRAP provisions passed. In this way, legislators use extreme and controversial anti-choice measures as a Trojan horse for insidious laws that chip away at a woman's right to choose.

Crisis Pregnancy Centers

Crisis pregnancy centers (CPCs) are so-called "abortion alternative" sites run by private organizations that claim to provide support, information, and medical care to pregnant women. CPCs use misleading tactics to draw women in, advertising themselves as legitimate health centers, purposely distorting the truth to take advantage of vulnerable women. In reality, CPCs do not present women with a full range of reproductive health options; instead, they often use false information about abortion to pressure women into continuing unwanted pregnancies.

CPCs, which now far outnumber abortion providers, receive significant government funding but are subject to minimal oversight.

Between 1996 and 2009, CPCs received some of the \$1.5 billion in federal funding allocated to abstinence-only education. Despite President Obama's effort to cut off funding for abstinence-only programs, Congress continues to allocate funds to them, including \$75 million in a spending bill passed in 2015.

According to a *Cosmopolitan* investigation, in addition to this federal funding, "[a]t least 11 states now directly fund pregnancy centers." In June 2015, Gov. John Kasich of Ohio signed a state budget that imposed new TRAP restrictions on abortion providers and allocated \$500,000 for crisis pregnancy centers, while Greg Abbott of Texas signed a state budget allocating more than \$9 million for alternatives-to-abortion services, double the previous level of funding. In addition, in 15 of the 28 states that now offer "Choose Life" license plates, a portion of the proceeds are donated to anti-choice organizations or CPCs.

In 2011, South Dakota became the first state to *require* women to visit one of two state-approved crisis pregnancy centers before obtaining an abortion. The law is currently on hold as it works its way through the courts.

The roughly 3,500 CPCs in the United States are largely run by three organizations that have close ties with anti-choice, Religious Right political organizations. The Religious Right behemoth Focus on the Family, for instance, has dispensed hundreds of grants for ultrasound machines for CPCs, claiming in 2012 to have saved "more than 120,000 precious lives" in the process.

CPCs have long been an arm of the Religious Right; the first CPC was established in Hawaii by Robert Pearson, who said of his work, “Obviously, we’re fighting Satan. A killer, who in this case is the girl who wants to kill her baby, has no right to information that will help her kill her baby.” Pearson went on to create an international network of CPCs and to train the people running them how to mislead women seeking abortion providers.

After an undercover investigation into CPCs in 2011, NARAL reported that “one Jewish researcher who posed as a pregnant woman was told at five centers she wouldn’t go to heaven unless she converted to Christianity. One volunteer challenged the woman to become a ‘born-again virgin.’”

CPCs use a wide array of tactics to lure in pregnant women, including free medical procedures, promises of unprejudiced support, and disguising themselves as actual medical facilities.

Once women seeking honest information about their choices enter CPCs, they are often inundated with a number of common lies meant to convince them to forgo an abortion. An undercover investigation of Virginia CPCs by NARAL found CPCs trying to scare women out of abortions by falsely claiming that abortion can cause breast cancer, infertility, psychological damage including “post-abortion syndrome,” and even death.

Mandatory Waiting Periods

Mandatory waiting periods require a woman to wait for a certain amount of time between consulting with a physician and exercising an abortion. Currently, 28 states require a woman

to endure a mandatory waiting period, usually 24 hours, between receiving state-regulated counseling and the actual abortion procedure. In 13 of those states, a woman must receive in-person counseling before the waiting period begins, requiring two separate trips to the abortion provider. Three states – Missouri, South Dakota, and Utah – require a 72-hour waiting period; in South Dakota, weekends and holidays cannot count toward the mandatory three-day wait. Oklahoma’s law requiring a 72-hour waiting period will go into effect in November 2015.

The multiple trips required by mandatory waiting periods can greatly increase the total cost of obtaining an abortion. Currently, nearly 90 percent of all U.S. counties lack an abortion provider, meaning many patients must travel hundreds of miles to reach the nearest clinic, an increased cost that disproportionately impacts low-income and rural women. Other hidden costs of mandatory waiting periods include the need to take unpaid time off from work, make childcare arrangements, and pay for lodging. According to a 2008 Guttmacher analysis, 42 percent of women obtaining abortions were living below the federal poverty level; 69 percent were living below 200 percent of the federal poverty level.

Because many women seeking abortions struggle to afford the cost, they must work to save money while the pregnancy progresses. Rather than changing women’s minds about abortion, waiting periods can simply hike up the costs. A study of Mississippi abortion levels before and after the implementation of a mandatory waiting period found that the law increased the number of Mississippi residents traveling out of state for abortions and drove more women to seek later-term abortions.

“Choose life” license plates, a portion of the proceeds for which are sometimes donated to anti-choice organizations or CPCs.



These paternalistic laws assume that women do not carefully consider their options before choosing abortion. In fact, evidence shows just the opposite.

These paternalistic laws assume that women do not carefully consider their options before choosing abortion. In fact, evidence shows just the opposite. Studies show that waiting periods have an adverse emotional impact on women and do not change their minds about abortion. The primary impact – and intent – of waiting periods is to make it more difficult for women to obtain the care they need and want, and to which they are legally entitled. A three-year research project that studied the impact of Texas’s 2011 restrictive reproductive health laws found a 24-hour waiting period negatively affected the emotional well-being of one-third of the respondents and caused them to pay an average of \$146 in additional costs.

Proponents of these laws claim they ensure that patients have time to receive counseling and consider all their options before choosing to have an abortion. This argument is simply a guise to hide the law’s true purpose of hindering women, especially low-income women, from accessing reproductive care.



Genetic Anomaly, Race- or Sex-Selective Abortion Bans

Conservative lawmakers are increasingly turning to seemingly innocuous bans on race- and sex-selective abortion in the effort to restrict women’s access to reproductive health care. Evidence suggests that the actual incidence of race- and sex-selective abortions in the U.S. is miniscule. In practice, these laws are nearly impossible to enforce and do nothing to combat actual discrimination. Instead, they perpetuate discrimination against targeted groups and serve as one more barrier to access.

In 2011, Arizona became the first state to ban race- and sex-selective abortions, making it a felony to perform or pay for an abortion sought due to the race or sex of the fetus. To date, seven states ban sex-selective abortions at some point in the pregnancy. A federal sex-selective abortion ban – the Prenatal Nondiscrimination Act (PRENDA) – has also been proposed, but failed to pass in the House in 2012. A version of the bill in the Senate currently has 13 cosponsors, but has yet to be brought to a vote.

Advocates are concerned that these bans, rather than preventing discrimination, will subject African-American and Asian-American women to discrimination and false assumptions about their motivations for seeking abortions. Higher rates of abortion among African-American women have led conservatives to claim that race-selective abortion is a widespread problem and even to allege that abortion rights advocates are perpetrating “genocide” against African-Americans. Likewise, advocates of sex-selective abortion bans have insinuated, without evidence, that they are needed to prevent Asian-American women from terminating pregnancies due to male preference. These claims are not only false, they are insulting to women making private, personal choices about abortion.

Some legislatures are now also attempting to restrict or ban abortion in cases of genetic anomaly, even in cases when a fetus has a genetic condition that is incompatible with life outside the womb. North Dakota, which passed its restriction in 2013, is currently the only state that bans abortions in cases of genetic anomaly.

Interference with Medical Providers: Legislators as OB/GYNs

Some of the most insidious laws seeking to limit women's access to reproductive care create barriers between women and their doctors by mandating that doctors provide medically inaccurate information or perform medically unnecessary procedures.

Restrictive laws do not protect women or lower rates of abortion; instead, they worsen the burden on women and may set back the trend toward early abortion. Such laws also waste medical resources by mandating unnecessary treatment and interfere with physician judgment. Instead of a decision made by a woman, in consultation with a medical professional and considering her health and circumstances, the government tells doctors what they must do, regardless of patient needs or medical necessity.

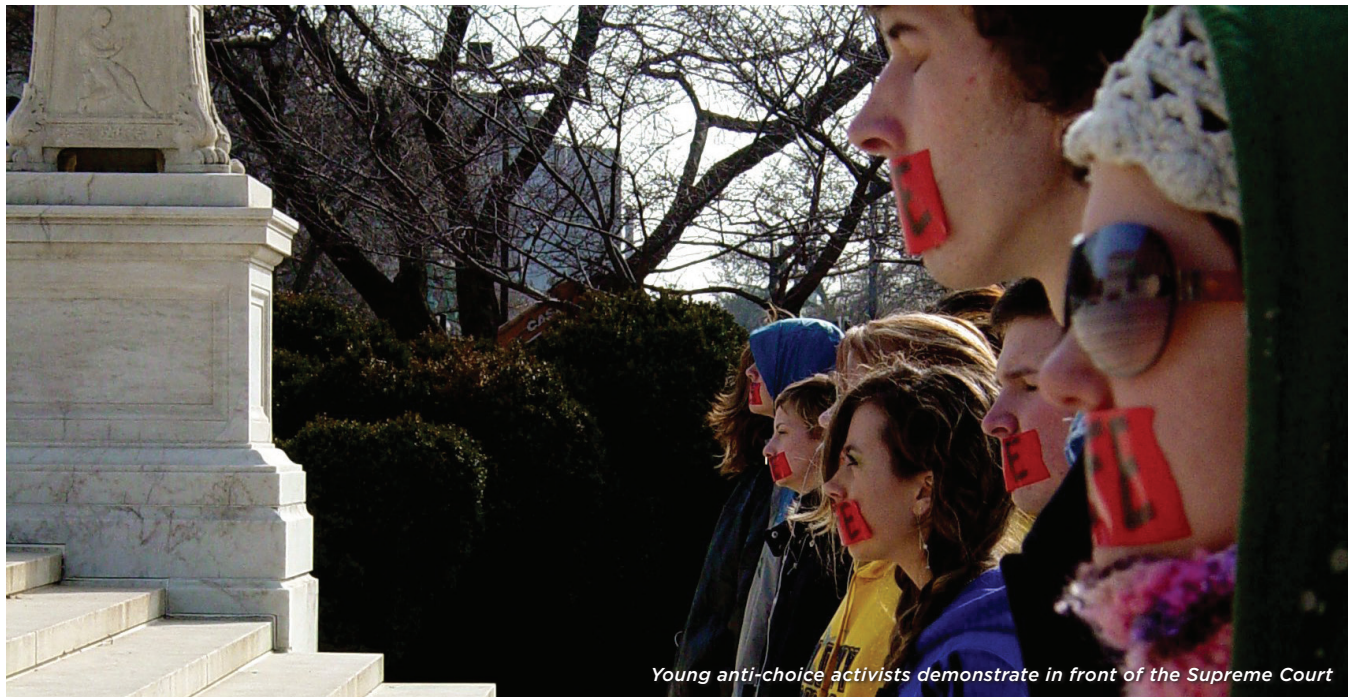
Outdated Constraints on Early-term Abortions

While in the first nine weeks of her pregnancy, a woman can choose to have a medication abortion rather than surgical abortion. In a medication abortion, the pregnancy is terminated by orally ingesting an FDA-approved medication consisting of the drugs mifepristone and misoprostol (sold under the brand name

Mifeprex). Medication abortion is a safe medical procedure – safe enough that the medication can be taken in the comfort of a woman's home – and by 2011 accounted for 36 percent of abortions before nine weeks of pregnancy.

The World Health Organization has long recommended that nurse-midwives, nurse-practitioners, and physician assistants be permitted to prescribe Mifeprex. However, outdated FDA guidelines state that only a licensed physician may prescribe Mifeprex, and the FDA-approved protocol calls for women taking the drug to make three separate visits to a doctor. On the first visit, the patient is counseled and given a dose of Mifeprex. Two days later, she returns for a second dose. Two weeks after that, she has a follow-up visit.

But subsequent research and substantial “off label” usage have shown that cumbersome requirements are severely outdated and place an unnecessary burden on women seeking safe and affordable care. As early as 2001, the year after the FDA approved Mifeprex, an estimated 83 percent of providers were not using the FDA guidelines for medical abortion. However, several states still require doctors to comply with some or all of these outdated guidelines, which places an unnecessary burden on women, as a way to further restrict abortion access.



Young anti-choice activists demonstrate in front of the Supreme Court



Four states require mifepristone to be provided in accordance with the outdated FDA protocol rather than in accordance with the simpler evidence-based protocol that has been proven to be equally safe and effective (the laws of two additional states, Arizona and Oklahoma, have been blocked by courts). The FDA recommends women take 600 mg of mifepristone, a level based on outdated research that is three times the necessary dosage of 200 mg currently prescribed by doctors. Such outdated and cumbersome requirements therefore not only place an unnecessary burden on women and abortion providers, but also pose potential health risks to women who must now take three times the necessary dosage, regardless of how that might impact their well-being. The FDA protocol also calls for the drug to be used only in the first seven weeks of pregnancy; it has since been found to be safe through the ninth week of pregnancy.

While federal appeals courts have upheld FDA compliance laws in Texas and Ohio, the Ninth Circuit Court of Appeals blocked Arizona's law, writing that "Arizona has presented no evidence whatsoever that the law furthers any interest in women's health" and that it served simply

to "ban medication abortions outright" for "a significant number of women." In August 2015, an Oklahoma judge struck down that state's law limiting off-label use of Mifeprex and similar drugs, noting that the law did not apply to other medications.

Thirty-eight states unnecessarily require clinicians who perform medication abortion procedures to be licensed physicians, and 18 states require that the clinician providing a medication abortion be physically present during the procedure. This requirement eliminates the option for providers to use telemedicine to prescribe medication for abortion remotely, which would increase accessibility and decrease cost.

Due in part to the introduction of Mifeprex in 2000, one-third of abortions occur at six weeks of pregnancy or earlier and 89 percent occur within the first 12 weeks. Laws that place unnecessary and even harmful restrictions on early-term abortion have one goal: to reduce the number of abortions provided by increasing costs and decreasing accessibility.

Mandatory Counseling Laws

Mandatory counseling laws are another tactic used by anti-choice legislators to interfere with the doctor-patient relationship. Such laws threaten a patient's health by requiring the provision of misinformation and preventing doctors from addressing a patient's needs on an individual basis. Currently, 35 states require that a woman receive counseling before obtaining an abortion, and 27 states detail the information with which a woman must be provided.

Of the 35 states that require some form of counseling, 28 require women to wait at least 24 hours between the counseling and the abortion procedure. Of these 28 states, 13 require this counseling be provided in person before the waiting period begins, thus necessitating two separate trips to the clinic. These laws therefore exacerbate the barriers that states have already put in place for women seeking abortions: a 2013 analysis of 2008 data found that "women who lived in a state with a 24-hour waiting period were more than twice as likely to travel greater distances as women in states with no waiting period requirement regardless of whether there was a two-visit requirement."

Many of these states additionally require abortion providers to give a woman false or misleading information or speeches aimed at dissuading her from an abortion.

Mandatory counseling laws too often resort to scare tactics by requiring abortion providers to give women false information about abortion risks. According to Guttmacher, of the 24 states that mandate information about abortion risks, four states include inaccurate material on the potential effect of abortion on future fertility; “five of the seven states that include information on breast cancer inaccurately assert a link between abortion and an increased risk of breast cancer”; and “seven of the 22 states that include information on possible psychological responses to abortion stress negative emotional responses.”

Twelve states require women to be told about the ability of a fetus to feel pain (which, as discussed below, is not supported by medical evidence) and five states require that the woman be told that personhood begins at conception.

An emerging tactic involves requiring providers to tell patients that it is possible to reverse a medication abortion partway through the procedure. Arizona and Arkansas enacted such laws, based on model legislation from Americans United for Life, within a week of each other in 2015; Arizona’s law is on hold while litigation is pending.

The idea of “abortion reversal” is based on the work of one physician, Dr. George Delgado, a frequent speaker at anti-abortion conferences, who claims to have reversed abortions by injecting supplemental progesterone between the two doses of mifepristone. But Delgado’s work is disputed by the mainstream medical community. The chairwoman of the

Arizona section of the American Congress of Obstetricians and Gynecologists told the *New York Times* that there is “no data behind it, absolutely no science to show that this is an effective method.” The “reversal” procedure could in fact be dangerous for women, with risks of “cardiovascular side effects, glucose tolerance issues [and] problems with depression in people who already had it.”



Anti-choice legislators who mandate the provision of biased and erroneous information under the guise of informed consent and empowerment corrupt the doctor-patient relationship, with potentially dangerous consequences to women’s health. Women seeking abortions who look to their doctors for comprehensive and accurate information are instead met with politically motivated scripts written by legislators devoted to obstructing their constitutional right to choice.

Mandatory counseling laws too often resort to scare tactics by requiring abortion providers to give women false information about abortion risks.

Mandatory Ultrasound Laws

Mandatory ultrasound laws are another way in which legislators interfere with the doctor-patient relationship. Such laws require abortion providers to perform an ultrasound on a woman seeking a first-trimester abortion, even though such a procedure is generally not medically necessary. Anti-choice activists claim that these laws help women to understand their decisions by giving them the benefit of more information. However, by mandating unnecessary medical procedures, these laws burden women, make abortion more costly and time consuming, waste medical resources, and interfere with private medical decisions.

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One physician at a Texas clinic, forced to describe a fetus with a severe molecular flaw, told his patient, "I'm so sorry that I have to do this - but if I don't, I can lose my license." After reading state-mandated literature on the risks of abortion, the physician informed the woman that "the legal side" of her abortion care would be over only when she returned to the clinic after a mandatory 24-hour waiting period: "Then [after the waiting period] we'll care for you and give you the information you need in the way we think is right."

Of the 24 states that have laws relating to the provision of ultrasounds before abortions, 13 mandate that an abortion provider perform an ultrasound on each woman seeking an abortion. Three of those states require the provider to show and describe the ultrasound image to the patient, and 10 require providers to offer the woman the opportunity to view the image.

In Wisconsin, Gov. Scott Walker signed into law one of the most invasive mandatory ultrasound laws in the nation, requiring women seeking an abortion to first obtain a medically unnecessary

ultrasound and providers to show and describe the image. Pro-choice activists have raised the concern that for most early-term pregnancies, only a transvaginal ultrasound would legally satisfy the required fetal anatomy a doctor must describe under the law. Walker infamously defended the law by saying that ultrasounds are just a "lovely thing" and a "cool thing out there."

In June 2015, the Supreme Court declined to review a lower court decision striking down a North Carolina law that would have required doctors to perform and narrate an ultrasound on a woman before she could have an abortion. The law would have forced doctors to place the ultrasound image in front of a woman's face and describe fetal development in full detail before

providing an abortion. There was not even an exception in the law for rape and incest victims or for women seeking the procedure because of a fetal anomaly.

In addition to being a further paternalistic effort to convince women to forgo an abortion, ultrasound requirements are yet another tactic to drive up the cost of the procedure, as

these required ultrasounds can cost anywhere between \$200 and \$1,200.

While proponents of mandatory ultrasound bills hope that they will convince women to opt out of the procedure they have already chosen to obtain, evidence shows that these laws have no such effect. A 2014 analysis of 15,575 medical records published in the *Journal of Obstetrics and Gynecology* found that 98.4 percent of women who chose to view an ultrasound still terminated their pregnancies.

In passing these laws, legislators betray



a fundamental misunderstanding about the reasons women choose to terminate their pregnancies. In reality, women primarily have abortions due to external circumstances (three-quarters of patients cited existing family obligations and financial constraints, and 61 percent already had children.) Mandatory ultrasound policies are a coercive effort at emotional manipulation that has no place in the law and whose only result is to harm women.

20-Week Abortion Bans

Twenty-week abortion bans, or “fetal pain” laws, which restrict abortion based on the spurious claim that the fetus can feel pain 20 weeks after fertilization, have been enacted in 11 states.

A federal 20-week abortion ban is now being considered in the Senate after passing the House in May 2015. The bill, known as the “Pain-Capable Unborn Child Protection Act,” would include exceptions for rape, incest, and the health of the mother. However, the bill would also require women who became pregnant due to rape to receive counseling at least 48 hours before having an abortion – a de facto waiting period – and in cases of rape involving minors, abortion providers would be required to alert the authorities.

Wisconsin Gov. Scott Walker was the most recent governor to sign a 20-week abortion ban into law. Wisconsin’s law, which contains no exceptions for rape or incest survivors, subjects noncomplying abortion providers to a fine of up to \$10,000 and up to three and a half years in prison.

The argument that a fetus can feel pain 20 weeks after fertilization – at about 22 weeks of gestation, the more commonly used measurement for the length of a pregnancy, which is dated to the last menstrual cycle – is refuted by the mainstream medical community. But these laws have a more insidious goal.

These laws are referred to as “20-week” bans although in more commonly used medical terms, they ban abortion at 22 weeks of pregnancy, or about two weeks before a fetus becomes viable outside the womb. Because these laws measure the length of a pregnancy from fertilization, rather than the more commonly used gestational age (an easier date



to pinpoint), they understate how closely they approach the fetal viability standard set by the Supreme Court.

The author of a Missouri 20-week viability-testing law that came close to toppling *Roe* in 1989 told *Mother Jones* this year that the 20-week mark “was chosen to push the envelope on when the state’s interest in protecting the life of the unborn could take place. It was chosen because it was earlier than the earliest limits of viability at the time, but not so early that the unborn child could never be viable.”

Only about one percent of abortions take place after 20 weeks of pregnancy; these include some heartbreaking cases of women discovering that their children will not live outside the womb.

With so-called “fetal pain” bills, anti-choice legislators are attempting to chip away at abortion access and build public support for their cause while simultaneously hoping to prompt a case that would allow the Supreme Court to further weaken or overturn *Roe*. These are nothing more than a thinly veiled attempt by anti-choice legislators to restrict a woman’s access to safe reproductive care in the hope of soon outlawing abortion all together.

PERSONHOOD AND HEARTBEAT BILLS

While the largest and best-funded anti-choice groups have embraced a strategic, incremental approach to ending legal abortion, a vocal and increasingly influential segment of the anti-choice movement is calling for more immediate and extreme measures. Blatantly unconstitutional head-on attacks against *Roe* – including “personhood” and “heartbeat” measures – are frequently blocked by voters, legislatures, and the courts. However, these attacks are increasingly becoming part of the national debate, as evidenced by former Arkansas Gov. Mike Huckabee’s impassioned defense of “personhood” measures in a nationally televised GOP presidential debate in August 2015.

Although many incrementalist activists fear that such measures will upset their carefully laid plans to chip away at abortion access and undermine *Roe* in the courts, their efforts are also aided by extreme policy proposals that can serve as cover for quieter efforts to chip away at choice.

Personhood Laws

The “personhood” movement defines life as beginning at conception. Therefore, personhood measures seek to change the legal definition of a “person” to include a fertilized egg, embryo, or fetus with the intent of outlawing all abortion as well as some common contraceptive methods that proponents argue prevent the implantation of a fertilized

egg. The movement, which enjoys support from prominent figures such as Alabama Supreme Court Chief Justice Roy Moore, opposes any abortion restriction containing exceptions for cases of rape, incest, or health of the pregnant woman.

This supposed “pro-life” agenda would therefore prevent doctors from providing appropriate care to women, even when their lives are in danger. Under personhood laws, doctors could face restrictions on their ability to treat life-threatening conditions such as ectopic and molar pregnancies that necessitate early termination. They also threaten to place women who have suffered miscarriages at risk of criminal prosecution.

State-level personhood amendments have faced considerable backlash when they are put before voters. Colorado voters have rejected personhood at the polls three times; the solidly conservative Mississippi soundly rejected personhood in 2011, as did North Dakota in 2014. But personhood continues to have strong defenders at the state and national level. In the last Congress, Sen. Rand Paul, a GOP presidential candidate, gained 21 cosponsors for his personhood bill in the U.S. Senate; a companion bill in the House had 132 cosponsors.

Incrementalist anti-choice groups fear that the personhood movement’s direct attacks on *Roe* could backfire, through both negative public opinion and adverse court

rulings. But it is important to remember that both sides of the movement share the same goal: outlawing abortion at all stages.

While prominent anti-choice groups such as the Heritage Foundation and AUL have tried to avoid publicly aligning themselves with the personhood movement, these groups have also quietly adopted the personhood movement’s goal for U.S. policy to recognize life as beginning at fertilization. During the debate surrounding the 2014 Supreme Court case *Burwell v. Hobby Lobby*, leading anti-choice organizations endorsed the view that emergency contraceptives and IUDs constitute abortion. This radical agenda, which was furthered by the *Hobby Lobby* majority’s decision to exempt certain for-profit employers from offering contraceptive coverage under the ACA, would have debilitating and far-reaching consequences for the millions of women who use birth control.

If anti-abortion groups were to succeed in pushing state or federal legislators to define certain contraceptive methods as abortifacients, the effects for women would be burdensome and costly. A woman seeking such emergency contraception such as Plan B in Mississippi, for instance, notes Joerg Dreweke in the Guttmacher Policy Review, “would need to make an initial trip to the provider to first undergo mandatory in-person counseling, as well as a mandatory ultrasound exam. She would then have to

wait a minimum of 24 hours before making the second trip to obtain the emergency contraceptives.” This would be the case even though Plan B’s effectiveness decreases over the 72-hour span during which it can be used to prevent a pregnancy.

Heartbeat Laws

Heartbeat bills seek to ban abortion after the point at which a fetal heartbeat can be detected by an ultrasound. A heartbeat can be detected as early as six weeks into pregnancy – before some women may even be aware that they are pregnant – but can only be detected using a transvaginal ultrasound. Under a heartbeat law, a woman seeking an early-term abortion may have to submit to this unnecessary and invasive procedure to find out if she can legally terminate an unwanted pregnancy.

Banning abortion after six weeks, before which many women don’t even know they are pregnant, places an



arbitrary limit on a woman’s right to choose and is clearly unconstitutional, setting up a direct challenge to *Roe*.

To date, North Dakota and Arkansas are the only two states to have enacted heartbeat laws, although similar laws are being considered by

several other states. North Dakota’s heartbeat law was struck down by a federal appeals court in July 2015. A federal judge struck down Arkansas’s law in May 2014.

Conclusion

Both camps of the anti-choice movement – those who support explicitly radical measures and those who favor quieter, smaller scale tactics – share the same goal: to completely criminalize abortion. They merely differ in how to accomplish this.

Short of a complete reversal of *Roe*, anti-choice activists and lawmakers recognize that quieter, incremental measures are their best hope for eliminating reproductive choice. By manipulating and disguising their goals for different audiences, anti-choice legislators are able to pass radical restrictions on access to reproductive health care without widespread public knowledge or opposition.

In June 2015, the Supreme Court granted a request from Texas abortion providers to put a hold on a lower court ruling that would have forced nearly all of the state’s abortion clinics to shut down. That lower court ruling upheld a set of TRAP laws signed into law in Texas in 2013 that caused more than a 75 percent reduction in abortion facilities in a two-year period in the name of “women’s health.” If the Supreme Court takes up the case, it will present the greatest legal test yet to the anti-choice movement’s “chipping away” strategy. The survival of *Roe* as a strong protector of women’s reproductive rights is in the balance.

For citations, please refer to the online version of this report at www.pfaw.org

HOW THE GOP AND FAR RIGHT ARE CHIPPING AWAY AT CHOICE:

- **Targeted Regulation of Abortion Providers (TRAP)** laws, like Texas's House Bill 2, which place unnecessary regulations on abortion providers with the aim of closing the clinics altogether.
- **Crisis pregnancy centers**, which have been found to provide women with false or misleading information, and are often not staffed by medical professionals.
- **Mandatory waiting periods**, which place an unnecessary burden on low-income women and those who live in one of the 90 percent of U.S. counties without an abortion clinic.
- **Genetic anomaly, race or sex selective abortion bans**, cynical efforts to create new obstacles to women's choice, often targeting women of color.
- **Interference with medical providers**, such as forcing doctors to read scripts written by politicians and requiring doctors to perform medically unnecessary procedures like early-term ultrasounds.
- **20-week abortion bans**, like the bill passed in the U.S. House and being considered by the Senate, which are aimed not only at diminishing abortion access but challenging the ban on pre-viability abortion prohibitions established by *Roe v. Wade*.



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