



NARAL
Pro-Choice America

Targeted Regulation of Abortion Providers (TRAP) Laws: Decreasing Access, Driving Providers Away

In the more than 40 years since *Roe v. Wade*, anti-choice activists and lawmakers have used nearly every trick and tactic to make abortion illegal. Because those efforts have largely failed, they have looked instead for ways to make the procedure inaccessible. One of those tactics is known as TRAP laws (Targeted Regulation of Abortion Providers). Typically promoted as regulatory schemes that are reasonable and appropriate, in fact, TRAP rules impose significant burdens on health-care providers, with the goal of forcing them to shut their doors.

Legal abortion is one of the safest medical procedures in the United States, and despite anti-choice claims to the contrary, excessive regulation of abortion providers is not intended to protect women's health nor will it have that effect. In fact, anti-choice lawmakers repeatedly have publicly revealed that their true intention is to block women from receiving abortion care. TRAP laws increase the cost and inaccessibility of abortion services, with no medical justification. Furthermore, they aim to reduce an already limited number of abortion providers by singling them out for unnecessary and onerous regulations, which can greatly increase the cost of providing abortion services and effectively drive them out of business. Finally, by demonizing abortion through extensive TRAP laws, anti-choice lawmakers are attempting to scare women and deter them from exercising their constitutional right to choose. Cumulatively, it is these anti-choice laws—and not the right to choose—that pose a real threat to women's health.

Pro-Choice Advocates Embrace Appropriate Medical Standards and Oversight

No one advocates more forcefully for women's health than the pro-choice community. NARAL Pro-Choice America endorses wholeheartedly any and all justified health and safety standards for medical providers.

- Abortion providers are already subject to the same requirements as other health-care professionals, and facilities that provide abortion care already must comply with the same health and safety regulations as comparable health centers. These include, but are not limited to, the federal Clinical Laboratory Improvement Amendments (CLIA), Health Insurance Portability and Accountability Act (HIPAA), and Occupational Safety and Health Administration (OSHA) requirements.¹ State and local governments also promote health and safety in all medical facilities through existing laws and regulations regarding sanitation and disease control, zoning, fire and disaster safety, and building codes. As just one example, Texas has more than 450 pages of regulations that apply to every medical

provider in the state.² And Arizona has more than 200 pages of regulations that apply to every medical provider in the state.³

- State laws already govern the licensure, scope of practice, and training of health-care professionals, who are also required to complete continuing medical education courses to maintain their certification and/or medical licensure.⁴ State licensing boards discipline and revoke the certifications/licenses of physicians and other health-care specialists who fail to meet professional standards. Moreover, medical malpractice statutes and case law already allow individuals to sue a physician who fails to comply with the proper standard of care.

Taken together, the current system works extremely well to ensure patients' health and safety, and NARAL Pro-Choice America supports enforcement of penalties against any medical provider who violates these basic standards of care.

TRAP Laws Are an Anti-Choice Political Ploy

Anti-choice advocates and lawmakers claim that TRAP laws protect women's health and safety, but such claims mask their real agenda. Instead, TRAP laws have no medical justification and are part of a very deliberate strategy designed to make accessing abortion as difficult as possible. An anti-choice group in South Carolina admitted as much:

The pro-life movement is hamstrung by *Roe v. Wade*. **Our strategy is to pass every kind of legislation that will be upheld by the current Supreme Court until we have a Supreme Court that will reverse *Roe v. Wade*.**⁵ (emphasis added)

The executive director of Ohio Right to Life, too, revealed the true intent of TRAP laws at a public forum in 2011:

We're going to introduce a law in Ohio that any facility that performs... five abortions or more in a year **have to meet the same standards as a hospital... to the point where they're not going to be able to stay open...**We've been chipping away and closing and closing and closing, and if we get this legislation we can close a whole heck of a lot more.⁶ (emphasis added)

In fact, the overt political meddling and the departure from sound science that Virginia's TRAP scheme represented drove the state's top public-health official to resign from her post. A physician who had served as health commissioner under two different governors cited the political motivation behind the state's new TRAP regulations, and the distortion of claims about health and safety concerns, as the reason for her resignation:

I personally committed to you [the governor] when I accepted your appointment that I would lower abortion rates in our state by both the application of evidence based approaches and also the thoughtful implementation of abortion

regulations...Unfortunately, how specific sections of the Virginia Code pertaining to the development and enforcement of these regulations have been and continue to be interpreted has created an environment in which my ability to fulfill my duties is compromised and in good faith I can no longer serve in my role.⁷

TRAP Laws are Onerous and Do Nothing to Protect Women's Health

A close look at most TRAP rules reveals their true purpose – to regulate abortion providers out of practice. Types of TRAP laws, and specific examples from states with onerous TRAP schemes, include:

Onerous Physical-Plant Restrictions

Among the most common TRAP regulations are those that require doctors to convert their practices needlessly to ambulatory surgical centers or mini-hospitals at great expense. Other TRAP regulations restrict abortion services to a hospital, an impossibility in many parts of the country. On the surface, these regulations may seem mundane, but in reality they only serve to block women's access to safe abortion.

These physical-plant schemes are not medically justified, do not improve patient care, and often require facilities to undergo new construction or costly renovation to comply with the law. The requirements are often extremely detailed, even to the point of absurdity. They can include rules about:

- Minimum size requirements for examination, procedure, and recovery rooms⁸
- Minimum number of bathrooms⁹
- Specific temperature settings for various parts of the building and regulations about ventilation systems¹⁰
- Separate locker rooms and toilets for male and female personnel¹¹
- The size of janitors' closets¹²

Ambulatory surgical center or mini-hospital requirements

- Virginia mandates that first-trimester abortion facilities become licensed as a category of hospital subject to an extensive regulatory scheme. The regulations specify the type of fabric that may be used on window coverings; require widths of five feet for public hallways and 3.8 feet for staff corridors; stipulate that outdoor components of heating and ventilation systems may not emit sounds louder than 65 dba units; dictate the ceiling height for the boiler room; and mandate that a provider have four parking spaces per procedure room.¹³
- In Kansas, regulations for abortion providers greatly exceed those for most other clinics and doctors' offices and, in some cases, are more specific than even those that apply to hospitals

and ambulatory surgical centers. The regulations require separate locker rooms for patients and staff to store clothing and belongings; mandate that each procedure room have its own janitorial closet of 50 square feet; and set air temperature requirements of 70 to 75 degrees in patient-recovery rooms and 68 to 73 degrees in procedure rooms.¹⁴

- Missouri has particularly extensive construction and design requirements mandating that procedure rooms be at least 12 square feet with ceilings at least nine feet high and doors at least 44 inches wide, corridors must be at least six feet wide, and separate counseling rooms are required and must be at least 10 square feet.¹⁵

Hospital requirements

- The U.S. Supreme Court declared an Ohio law requiring that second-trimester abortion be provided in a hospital unconstitutional. The decision states that such a mandate “impose[s] a heavy, and unnecessary, burden on women’s access to a relatively inexpensive, otherwise accessible, and safe abortion procedure.”¹⁶ The court concluded the regulation was unreasonable,¹⁷ particularly in light of the fact that second-trimester abortion services were provided safely in outpatient clinics.¹⁸
- A court enjoined an Oklahoma regulation that restricts second-trimester abortion services to hospitals, after the state conceded the law was unconstitutional and medically unnecessary.¹⁹ At the time, only three hospitals in the state permitted such services at their facilities, and the substantial added cost of obtaining care at a hospital rather than a clinic could have further restricted access for many women.²⁰

Building and external-grounds specifications that border on the ridiculous

- Anti-choice lawmakers in South Carolina have manipulated the regulatory process to promulgate requirements that seem designed simply to burden abortion providers. For instance, the regulations extend to the landscaping outside the facility, dictating what type of grass or vegetation may be planted on the grounds and include specifications about the upkeep of adjacent buildings and externally stored garbage cans.²¹
- North Carolina requires that clinics include at least 18 additional physical components, including its own laboratory and a “nourishment station” for “serving meals or in-between-meal snacks.”²²

Detailed and unnecessary building requirements are particularly suspect when they fail to include a grandfather clause permitting an existing abortion facility to bypass the requirements until it undergoes new construction or major renovations.

Hospital-Proximity and -Privileges Requirements

Equally unrelated to medical need or patient safety, some TRAP regulations require that abortion providers locate their clinics within a certain radius of a hospital, maintain admitting privileges at a hospital within a specified distance, or enter into a written transfer agreement with such a hospital. These restrictions are purportedly to ensure appropriate care in case of emergency. Yet, these requirements are unnecessary not only because the rate of complications associated with abortion care is incredibly low, but also because federal law requires hospital emergency rooms to stabilize any patient with an emergency condition, regardless of whether their doctor has admitting privileges at the hospital.²³ Requiring providers to have admitting privileges falsely implies to the public that abortion care is dangerous, making it difficult, if not impossible, for doctors to practice in certain parts of the country.

Proximity to a hospital

Eighty-nine percent of counties in America have no abortion clinic.²⁴ In rural areas, doctors—and hospitals—are even fewer and farther between. Laws requiring abortion clinics to be within a certain distance of a hospital are eliminating abortion services in large regions of the country, which, in fact, is the motivation behind many of these requirements. Imposing a geographic restriction would clearly disqualify many women whose doctors' offices are not located within an arbitrary range of a hospital that these laws require.

Transfer agreements

Additionally, transfer agreements, which require abortion clinics to get a hospital to state in writing that the hospital will admit any emergency patients, may be difficult or impossible to obtain, given the contentious nature of abortion politics and that nothing requires a hospital to enter into such an arrangement. Although hospitals may acknowledge their legal duty to provide emergency care,²⁵ they are often reluctant to put such an agreement in writing when it comes to abortion.²⁶

- In 2013, anti-choice Ohio Gov. John Kasich (R) signed into law a state budget that included anti-choice provisions further restricting an abortion provider's ability to obtain a transfer agreement. The first provision blocked public hospitals from entering into transfer agreements with abortion providers. The second provision gave the director of the state health department (a political appointee) unilateral authority to revoke existing variance waivers—waivers that had allowed clinics to operate without a transfer agreement (in many instances, providers had waivers for several years). Since passage, nearly half of Ohio's abortion providers have closed their doors.²⁷

In late October 2014, state health officials began the process of closing down the last abortion clinic in Cincinnati—positioning it to become the largest metropolitan area without any abortion provider. However, in what was likely a political maneuver to allow Gov. Kasich to appear moderate before a rumored presidential bid, the new health director granted the provider a waiver, allowing it to keep its doors open. Before that intervention,

the provider had been waiting for over a year for the department to act on the waiver request.²⁸

Additionally, as Ohio legislators were negotiating the state budget in July 2016, they added a number of additional attacks on women's reproductive rights—which anti-choice Gov. Kasich signed into law. Included in the state budget are additional TRAP provisions, including requiring an abortion provider to be within 30 miles of a hospital (a provision intended to close the last remaining clinic in Toledo), and the automatic denial of any licensure application for abortion providers if the health department does not act on it. Given the health department's track record of dragging its feet on licensure and waivers, this provision is especially egregious.²⁹

- In Lancaster, Pennsylvania, an anti-choice political candidate urged activists to pressure local hospitals into canceling or refusing to renew their written transfer agreements with a Planned Parenthood clinic, after it announced plans to begin providing abortion services. The local Catholic hospital issued a statement opposing abortion and declined to renew its written transfer agreement with the clinic. The secular hospitals would only sign letters generally stating they would care for clinic patients and refused to list the care they would provide. Pennsylvania's health department determined that these letters do not satisfy the written transfer agreement requirement.³⁰

It is important to note here again that all U.S. hospitals already are required by federal law to stabilize a patient requiring emergency care. A "transfer agreement" is unnecessary; its only purpose is to erect another barrier for abortion providers to surmount in order to practice medicine.

Admitting privileges

In some regions, providers contend not only with anti-choice bias but also face legitimate logistical barriers; when physicians travel into one state from another for their practice, hospitals may not readily grant them admitting privileges when they only practice in the region on an intermittent basis. Admitting-privilege requirements mandate that physicians obtain credentials at a nearby hospital, but nothing ensures that hospitals will consider the request, let alone grant such privileges. Therefore, even doctors who make every effort to comply with the new mandates, but cannot gain admitting privileges, will be driven out of practice.

- In 2012, Mississippi enacted a law requiring all physicians who provide abortion services at the state's only remaining clinic to maintain both admitting and staff privileges at a local hospital, a near impossibility when nothing in the law requires hospitals to grant such privileges.³¹ A state representative explained it this way:

We have literally stopped abortion in the state of Mississippi. Three blocks from the Capitol sits the only abortion clinic in the state of Mississippi. A bill was drafted. It said,

if you would perform an abortion in the state of Mississippi, you must be a certified OB/GYN and you must have admitting privileges to a hospital. **Anybody here in the medical field knows how hard it is to get admitting privileges to a hospital...**It's going to be challenged, of course, in the Supreme Court and all — but **literally, we stopped abortion in the state of Mississippi, legally,** without having to — *Roe v. Wade*...And of course, there you have the other side. They're like, "Well, the poor pitiful women that can't afford to go out of state are just going to start doing them at home with a coat hanger." That's what we've heard over and over and over. But hey, you have to have moral values. You have to start somewhere.³² (emphasis added)

One of the clinic's physicians already had the required hospital privileges but none of the other doctors was able to obtain them. In 2014, after years of litigation, the Fifth Circuit Court of Appeals ruled that the clinic could remain open without providers obtaining admitting privileges at a local hospital.³³ The state of Mississippi has since asked the U.S. Supreme Court to review the lower court's ruling.³⁴

Judges in other states also have enjoined laws that require providers to obtain admitting privileges at a nearby hospital, finding that the laws create an undue burden on a woman's right to choose. In fact, judges have enjoined similar laws in Alabama, Louisiana, North Dakota, Oklahoma, and Wisconsin — in addition to the aforementioned Mississippi. The Wisconsin attorney general asked the U.S. Supreme Court to review the decision concerning its law,³⁵ which the court announced it would not do in July 2014. Given that there now is a split in circuit court decisions, we're expecting the Supreme Court will choose to take up the issue in the near future.

The Texas Experience

In 2013, after an intense and nationally publicized debate, Texas enacted an omnibus anti-choice bill that includes an admitting-privileges requirement and a requirement that forces every abortion clinic to convert its practice needlessly into a mini-hospital or ambulatory surgical center (ASC). The intent of these requirements was clear: to close as many abortion clinics as possible. In fact, when a pro-choice group tweeted an infographic illustrating the clinics that would have to close as a result, Texas Lt. Gov. David Dewhurst (R) replied, "We fought to pass SB5 thru the Senate last night, & this is why!"¹

Nearly one million Texas women have been affected by these restrictions.³⁶ Since passage, a whopping 22 abortion clinics — more than half of all abortion providers in the state — have closed because of the admitting-privileges requirement. All but a handful of the remaining clinics would close under the ASC requirement, including all in the East Texas region and the Rio Grande Valley.³⁷ Clinic closures in the state have resulted in an average wait time of up to 20 days before women can get an appointment for abortion care.

The law has been the subject of intense litigation. In 2014, the Fifth Circuit Court of Appeals issued a decision that allowed the admitting-privileges restriction to remain in effect,³⁸ and some months later, the Fifth Circuit allowed the ASC requirements to go into effect. Soon after in 2015, the U.S. Supreme Court intervened by granting an emergency stay in the case.³⁹ This action provided a temporary reprieve for abortion providers — and the women of Texas — by

(cont.)

allowing several sites to reopen, including a clinic in the Rio Grande Valley and a clinic in East Texas (El Paso).

In September 2015, pro-choice litigators—on behalf of abortion providers in Texas—asked the U.S. Supreme Court to review the case.⁴⁰ The outcome of this case will have a significant impact not only on the women of the state of Texas and their families, but on women’s ability nationwide to access their constitutional right to choose.

¹ After three special sessions and Sen. Wendy Davis’ (D) historic 13-hour filibuster, the eventual bill that was enacted was H.B.2.

Patient-Privacy Violations

Some TRAP regulations authorize state officials to conduct inspections of abortion facilities and their records without an adequate protection in place for patient privacy. NARAL does not oppose reasonable provider inspections—even those that are unannounced—but in some instances, there is a credible reason to suspect such a requirement may be misused to serve a political, not public health, agenda. Additionally, courts have found regulations permitting inspections without expressly ensuring the confidentiality of records are unconstitutional because they impose “significant” and “unnecessary” burdens on women exercising their right to choose.⁴¹

- In Arkansas, the state has extensive warrantless access to providers' facilities. "Any authorized representative of the Arkansas Department of Health shall have the right to enter upon or into the premises of any Abortion Facility at any time in order to make whatever inspection it deems necessary." The regulations make no reference to patient privacy, confidentiality measures, or whether clinic activities may be disrupted.⁴²
- In South Carolina all licensed facilities are subject to inspection at any time, and "inspectors shall have access to all properties and areas, objects, records and reports, and shall have the authority to make photocopies of those documents required in the course of inspections or investigations." There are no provisions that protect the privacy and/or confidentiality of the patients.⁴³

TRAP Schemes Threaten Women’s Health

TRAP measures are not about protecting women’s health, because women’s health is safest when abortion is legal. Naturally, any medical procedure carries a small risk, but research confirms that the risk of death from abortion is lower than that from a shot of penicillin.⁴⁴ The Centers for Disease Control and Prevention reports the mortality rate associated with legal abortion procedures is 0.6 per 100,000 abortion procedures.⁴⁵ Conversely, when it is illegal, abortion is very dangerous to women’s health.

By burdening providers with extensive regulations, TRAP laws make abortion more difficult and expensive to obtain, often leading to additional medical costs on women who can least afford them. One expert in a legal challenge to a TRAP scheme in South Carolina testified that even a \$25 increase in cost will prevent one or two percent of low-income women seeking

abortion care from obtaining the procedure.⁴⁶ Because most states fail to cover abortion services under their state-run medical-assistance programs,⁴⁷ lower-income women may be forced to delay abortion services while they raise the necessary funds—thus increasing the risk to their health—or they may be forced to forgo legal abortion altogether.⁴⁸

In a 2011 analysis in the *New England Journal of Medicine*, a health-care economist studied state TRAP laws and concluded that restrictions aimed at shutting down providers, or “supply-side” policies, had little effect on demand for abortion. Instead they either forced women to travel farther to obtain health care or denied those with the fewest resources the ability to access wanted services. The study predicts that “making access to abortion unnecessarily costly [through such restrictions] will probably result in clandestine abortions and unintended childbearing among families with the least resources and the fewest options.”⁴⁹

The Best Way to Reduce the Need for Abortion is Prevention— Not Making Abortion More Difficult and Less Accessible

TRAP laws are yet another example of anti-choice political forces presenting a solution in search of a problem. Dr. David Grimes, former chief of the branch of the Centers for Disease Control and Prevention that monitors abortion safety, explains: “I can say with confidence that these regulations will not have a single positive impact on women’s health.... Having published on every hemorrhaged abortion death in the United States, I can assure you that not a single one was caused by a door width.” Dr. Grimes refers to TRAP laws as “the ‘antithesis’ of good medical policy,” stating that, in “public health, we identify a problem, figure out the causes, look for solutions, and implement them. Here we see a vigorous response in the absence of a problem. It’s science run amok. It’s public health run backwards.”⁵⁰

Instead of working to impede access to safe, legal medical procedures and using scare tactics to accomplish anti-choice goals, lawmakers should instead pass legislation that would *prevent* unintended pregnancies and thus reduce the *need* for abortion. That is the right way to improve women’s health.

Conclusion

Abortion is an extremely safe procedure when it is legal. Having failed to make it illegal, anti-choice activists are trying instead to make it unavailable, and one strategy for doing so is to impose onerous, medically unnecessary restrictions on abortion providers. Any such regulations must be carefully assessed to determine their true purpose and effect on women’s health and the right to choose. Those that single out abortion providers and create rigid, unreasonable standards that do not protect or improve patient safety, and which no other medical providers must meet, should be rejected.

January 1, 2016.

Notes:

- ¹ National Abortion Federation, *The TRAP: Targeted Regulation of Abortion Providers* (2007).
- ² On file with NARAL Pro-Choice America.
- ³ On file with NARAL Pro-Choice America.
- ⁴ National Abortion Federation, *The TRAP: Targeted Regulation of Abortion Providers* (2007).
- ⁵ Barry Yeoman, *The New Abortion War*, GLAMOUR, Feb. 2002, at 105.
- ⁶ Videoclip: Saturday Morning Public Forum Featuring Guest Speaker Mike Gonidakis, Executive Director of Ohio Right to Life on Pending Ohio Legislation Including the Heartbeat Bill." March 12, 2011 at <http://www.youtube.com/user/AMFANEdu#p/a/u/2/MKcgxljoe40> (last visited Nov. 6, 2015, also on file with NARAL Pro-Choice America).
- ⁷ Letter from Karen Remley, Commissioner, Virginia Dept. of Health, to Gov. Bob McDonnell, Governor of Virginia. (Oct. 18, 2012) at <http://www.scribd.com/doc/110467930/Virginia-Health-Commissioner-Karen-Remley-s-resignation-letter> (last visited Nov. 6, 2015).
- ⁸ See *Greenville Women's Clinic*, 66 F.Supp. 2d at 703, 716-18 (enjoining regulations, including minimum size requirements of recovery and procedure rooms, after finding costs of renovation and other costs of compliance are high); see also *Ragsdale*, 841 F.2d at 1362, 1373-74 (finding room size requirements not justified by important state health interests); *Birth Control Centers*, 743 F.2d at 364-65 (finding "significant impact" on the right to choose first trimester abortion where staffing, structural, and equipment regulations, which included room size requirements, would greatly increase the cost of abortions).
- ⁹ *Pro-Choice Mississippi v. Thompson*, No. 3:96CV596BN, (S.D. Miss. Sept. 28, 1996) (transcript of bench opinion) at 19-20 (preliminarily enjoining requirement of five separate bathrooms); see also *Greenville Women's Clinic*, 66 F.Supp. 2d at 703, 723-24 (enjoining regulations specifying type of bathroom equipment); see also *Birth Control Centers*, 743 F.2d at 364-65 (finding "significant impact" on the right to choose first trimester abortion where staffing, structural, and equipment regulations, which included minimum toilet requirements, would greatly increase the cost of abortions), 508 F.Supp. at 1382 (minimum toilet requirements).
- ¹⁰ See *Greenville Women's Clinic*, 66 F.Supp. 2d at 703, 723-24 (enjoining regulations specifying direction of air flow between rooms and requiring temperature control system that maintains temperature between 72 and 76 degrees); see also *Ragsdale*, 841 F.2d at 1362, 1374 (finding that regulations prescribing "specific air pressure relationships between rooms and specific air change ratios" were "unrelated to the safety of first and early second trimester abortions" and imposed "substantial burden").
- ¹¹ *Pro-Choice Mississippi v. Thompson*, No. 3:96CV596BN, (S.D. Miss. Sept. 28, 1996) (transcript of bench opinion) at 19-20; see also *Ragsdale*, 841 F.2d at 1362, 1373-74 (finding physical plant regulations, which included requirement of a lounge, lockers, separate toilets, and separate changing space for male and female staff, not justified by important state health interests).
- ¹² See *Greenville Women's Clinic*, 66 F.Supp. 2d at 703, 723-24 (enjoining regulations setting forth specific requirements for janitor's closets); see also *Birth Control Centers*, 743 F.2d at 364-65 (finding "significant impact" on the right to choose first trimester abortion where staffing, structural, and equipment

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- regulations, which required a janitor's closet with service sink, would greatly increase the cost of abortions), 508 F.Supp. 1366, 1382 (janitor's closet with sink); *Ragsdale*, 841 F.2d at 1362 (preliminarily enjoining regulations that include requirement of separate janitor's closet for surgical suite).
- ¹³ 12VAC5-412 Draft Emergency Regulation and Notice of Intended Regulatory Action Agency Background Document incorporating 2010 Facility Guidelines Institute guidelines.
- ¹⁴ Kan. Admin. Regs. §§ 28-34-133 (3), 28-34-133 (15), 28-34-134(a).
- ¹⁵ Mo. Code Regs. Ann. tit. 19, §§ 30-30.070(2)(B), .070(2)(C), .070(2)(M), .070(2)(Z).
- ¹⁶ *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 438 (1983); see also *Planned Parenthood Association v. Ashcroft*, 462 U.S. 476, 481-82 (1983).
- ¹⁷ *Akron Center for Reproductive Health*, 462 U.S. at 438.
- ¹⁸ *Akron Center for Reproductive Health*, 462 U.S. at 436-37.
- ¹⁹ *Reprod. Servs. v. Keating*, 35 F. Supp.2d 1332 (N.D. Okla. 1998); David Harper, *Clinics Get Go-Ahead to Perform Abortions*, TULSA WORLD, Dec. 16, 1998, A1.
- ²⁰ *Who Decides? A State-by-State Review of Abortion and Reproductive Rights* (Washington, D.C.: The NARAL Foundation, 1999), 177.
- ²¹ 61-12 S.C. Code Ann. Regs. 605B, 605C, 606, 806, 807L(1).
- ²² N.C. ADMIN. CODE tit. 10, r. 14E.0207
- ²³ 42 U.S.C.A. § 1395dd(b) (Emergency Medical Treatment and Active Labor Act, "EMTALA").
- ²⁴ Rachel Jones et al., *Abortion Incidence and Service Availability In the United States, 2011*, PERSP. ON SEXUAL & REPRO. HEALTH, Mar. 2014, 46(1).
- ²⁵ *Clinic Asks State for Approval on Abortion Request: Planned Parenthood Seeks OK Despite Lacking Emergency Patient Transfer Pact*, INTELLIGENCER JOURNAL, Feb. 5, 2000, B1.
- ²⁶ *Greenville Women's Clinic*, 66 F.Supp. 2d at 721; *Pro-Choice Mississippi v. Thompson*, No. 3:96CV596BN, (S.D. Miss. Sept. 28, 1996) (transcript of bench opinion) at 21.
- ²⁷ Jessie Balmert, *State Moves to Close Last Abortion Clinic Here*, CINCINNATI.COM, Sept. 25, 2015 at <http://www.cincinnati.com/story/news/2015/09/25/state-moves-close-last-abortion-clinic-here/72812634/> (last visited on Nov. 6, 2015).
- ²⁸ Tara Culp-Ressler, *Cincinnati Poised to Become Largest Metropolitan Area Without Any Abortion Clinics*, THINK PROGRESS, Oct. 24, 2014 at <http://thinkprogress.org/health/2014/10/24/3584360/cincinnati-abortion-clinics/> (last visited Nov. 6, 2015).
- ²⁹ Allie Gross, *How Ohio Gov. John Kasich is Making Life Hell for Women Seeking Abortions; The newest GOP candidate has signed every single restriction on abortion and family planning that has landed in front of him*, MOTHER JONES, Jul. 27, 2015 at <http://www.motherjones.com/politics/2015/07/wolf-sheeps-clothing-gov-kasichs-reproductive-rights-record> (last visited on Nov. 6, 2015).
- ³⁰ Gil Smart, *Abortion Foes Try Hospitals: Candidate Hopes If Planned Parenthood Can't Get Agreements for Referrals, He Can Stop Clinic*, SUNDAY NEWS, Oct. 19, 1998, A1; *Clinic Asks State for Approval on Abortion Request: Planned Parenthood Seeks OK Despite Lacking Emergency Patient Transfer Pact*, INTELLIGENCER JOURNAL, Feb. 5, 2000, B1; *Preventing Abortion at Planned Parenthood: Lancaster, Pennsylvania*, "United for

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- Life," available at <http://www.nrlc.org/uploads/factsheets/FS15PPPennsylvania.pdf> (last visited Nov. 6, 2015). For the Pennsylvania administrative regulations applicable to abortion providers, see 28 Pa. Code §§ 29.31 et seq.
- ³¹ MISS. CODE ANN. § 41-75-1 (2012).
- ³² David Badash, *GOP Lawmaker: Coat Hanger Abortions Support 'Moral Values'*, May 15, 2012, THE NEW CIVIL RIGHTS MOVEMENT at <http://thenewcivilrightsmovement.com/gop-lawmaker-applauds-coat-hanger-abortions-as-supporting-moral-values/politics/2012/05/15/39614> (last visited Dec. 2, 2014).
- ³³ *Jackson Women's Health Organization, et al. v. Mary Currier, State Health Officer of the Mississippi Department of Health, et al., Petitioners*, No. 13-60599, (5th Cir. 2014).
- ³⁴ *Mary Currier, State Health Officer of the Mississippi Department of Health, et al., Petitioners v. Jackson Women's Health Organization, et al.* No. 13-60599, petition for cert filed (5th Cir. 2014).
- ³⁵ *J.B. Van Hollen v. Planned Parenthood of Wisconsin, Inc.*, 738 F.3d 786, 798 (7th Cir. 2013) petition for cert. filed (U.S. Mar. 19, 2014) (No. 13-) at <http://www.doj.state.wi.us/sites/default/files/2014-news/petition-for-writ-certiorari-20140319.pdf> (last visited Nov. 6, 2015).
- ³⁶ Irin Carmon, *5th Circuit Decision to Close Most of Texas Abortion Clinics*. MSNBC, Oct. 2, 2014, at <http://www.msnbc.com/msnbc/5th-circuit-decision-close-majority-texas-abortion-clinics> (last visited Nov. 6, 2015); Daniel Grossman, et al. *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, *Contraception* 90(5): 496-501.
- ³⁷ Amelia Thomson-DeVeaux, *The Last Rural Abortion Clinics in Texas Just Shut Down*, MOYERS AND COMPANY, Mar. 9, 2014 at <http://billmoyers.com/2014/03/09/the-last-rural-abortion-clinics-in-texas-just-shut-down/> (last visited Nov. 6, 2015).
- ³⁸ Jonathan H. Adler, *Fifth Circuit Upholds Controversial Texas Abortion Law*, Mar. 28, 2014, THE WASHINGTON POST at <http://www.washingtonpost.com/news/volokh-conspiracy/wp/2014/03/28/fifth-circuit-upholds-controversial-texas-abortion-law/> (last visited Nov. 6, 2015).
- ³⁹ *Whole Woman's Health v. Cole*, No. 14-50928, (stayed pending appeal), (Jun. 29, 2015).
- ⁴⁰ *Whole Woman's Health v. Cole*, No. 14-50928, petition for cert filed (5th Cir. 2015).
- ⁴¹ *Greenville Women's Clinic*, 66 F.Supp. 2d at 698, 735.
- ⁴² Ark. State Bd. of Health, Rules and Regulations for Abortion Facilities § 4(J).
- ⁴³ S.C. Code Regs. 61-12.102 (F).
- ⁴⁴ William Cates, Jr, David A. Grimes, & Kenneth F. Schulz, *The Public Health Impact of Legal Abortion: 30 Years Later*, 35 GUTTMACHER POL'Y REV. 1 (2003).
- ⁴⁵ Pazol, Karen et al., Centers for Disease Control & Prevention, *Abortion Surveillance – United States, 2010*, Surveillance Summaries Vol. 62 (2013).
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